

NYC

EMPLOYEE BENEFITS PROGRAM

• GENERAL INFORMATION BOOKLET AND • SUMMARY PROGRAM DESCRIPTION •



1989

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Through collective bargaining agreements, the City of New York and the municipal unions have cooperated in the design of the benefits for the City Employee Benefits Program. The benefits are designed to provide you with the fullest possible protection that can be purchased with the available funding.

The City's Employee Benefits Program provides health benefits to approximately one million individuals and has annual premiums over \$700 million—making New York City the largest purchaser of employee health services in the Greater New York area. Administered by the Mayor's Office of Municipal Labor Relations, the Employee Benefits Program continues to receive a strong Mayoral commitment to provide the finest available health care coverage.

Employees and retirees may choose from the following plans:

1. Group Health Incorporated—Comprehensive Benefits Plan/Empire Blue Cross and Blue Shield (GHI-CBP/EBCBS)
2. Group Health Incorporated—Type C/Empire Blue Cross and Blue Shield (GHI Type C/EBCBS)
3. Empire Blue Cross and Blue Shield HEALTHNET
4. The Health Insurance Plan of Greater New York/Health Maintenance Organization (HIP/HMO)
5. HIP CHOICE
6. Sanus/New York Life
7. TOTAL HEALTH
8. US Healthcare
9. Med-Team (DC 37 members only)
10. Med-Plan (New enrollments or transfers must be HHC employees or non-Medicare eligible retirees of HHC)
11. Metropolitan Health Plan (HHC employees and non-Medicare eligible retirees only)
12. Mid-Hudson Health Plan
13. WellCare

This "Summary Program Description" provides brief descriptions and a comparison of benefits of all available programs.

This booklet also provides you with important general information concerning the City Employee Benefits Program. You will receive an in-depth description of the plan you have chosen from your health carrier after you enroll.

We urge you to read this booklet carefully and use the benefits wisely.

The City Employee Benefits Program depends upon continued intelligent use of health benefits by employees to help control costs. In these times of rapidly rising health care costs, any unnecessary use of health benefits adds further to costs and could limit the possibility of future benefit improvements. Proper usage now could mean greater benefits later.

It is our hope that you and your family will enjoy excellent health and have little occasion to use the services available through the Program. Should the need arise, however, you may be assured that the New York City Employee Benefits Program will help meet your needs.

CHOOSING A HEALTH PLAN

To select a health plan that best meets your needs, you should consider at least 4 factors:

1. **COVERAGE:** The services covered by the plans differ. For example, some provide preventive services while others don't cover them at all; some plans may cover chiropractic services and routine podiatric (foot) care while others don't.
2. **CHOICE OF DOCTOR:** Some plans provide partial reimbursement when non-participating providers are used. Other plans only pay for or allow the use of participating providers.
3. **ACCESS:** Certain plans may have participating providers or centers that are more convenient to your home or workplace.
4. **COST:** Some plans require payroll and pension deductions for basic coverage. The cost of optional riders also differs. (These costs are compared on charts at the end of this booklet.) Some plans require a small co-payment for each routine doctor visit. Some plans require subscribers to pay a yearly deductible before the plans will pay for the use of non-participating doctors. If a plan does not cover certain types of services that you expect to use, you must also consider the out-of-pocket cost of these services.

If you want further information on benefits, participating doctors, office locations, etc., you can call the plans you are interested in directly. Telephone numbers are listed at the end of each plan description.

DEFINITIONS

The following explanation of terms will help you understand what you will be reading in this booklet.

Co-payment

A fixed amount of money that the patient must pay, which is a part of the cost for certain services provided by their health plan (example: \$8.00 co-payment for routine medical check-up in a doctor's office).

Covered Services

Services for which the health plan will pay either partially or in full.

Co-insurance

The portion, generally a percentage, of the covered expenses approved by the health plan that is not paid by the plan. Covered expenses are generally less than actual submitted charges. (Example: GHI-CBP pays 80%, after the deductible, of a covered expense. The remaining 20% is the co-insurance.)

Deductible

An initial payment for medical services for which patients are responsible before their health plan will begin to pay for services. (Example: GHI yearly deductible of \$135.00 per covered person).

Eligibility

Eligibility for health coverage for employees, retirees and dependents is defined in Section One, paragraph B 1, 2, and 3.

Health Maintenance Organization (HMO)

An organized system of health care that provides hospital and medical services to its members. Individuals and/or families

who choose to join a particular HMO can receive health care at little or no cost provided they use the HMO's doctors and facilities. HMO members choose a family physician (participating provider) from within their HMO network, and they must go through this physician for all medical services, referrals and non-emergency hospitalizations. If a physician from outside of the health plan is used without a referral from an HMO physician, the patient is responsible for all bills incurred.

Individual Practice Association (IPA)

A group of independent doctors who provide services to HMO members while maintaining their private practice.

Major Medical Benefits

The portion of your health plan that partially reimburses health care services you receive from non-participating doctors. You must pay these doctors directly. The reimbursement is subject to annual deductibles and co-insurance. The amount to be reimbursed for any procedure is either based on a scheduled amount or on reasonable and customary charges (HIP CHOICE, GHI-CBP, DC 37 Med-Team).

Managed Care

The review, by physicians and other specially trained professionals, of proposed hospital admissions and certain out-patient procedures. This helps ensure that only medically necessary services are used, and that they are rendered in the most appropriate setting.

Medicare Risk Plans

Medicare subscribers enrolled in Medicare Risk Plans can ONLY receive services through their health plan. This means that if they use services outside of their plan, Medicare will NOT pay for them nor will they be paid for through their plan. (Medicare Risk Plans: US Healthcare, HIP VIP, TOTAL HEALTH).

Out-of-pocket expenses

Payments for services paid directly by the patient which are not reimbursed.

Paid-in-full benefits

Benefits which are not paid for by the patient. They are paid for by that patient's health plan.

Participating Providers

Medical providers who accept payment directly from health plans. The patient pays a small co-payment, or nothing at all, when using these providers. Each plan provides members with a list of participating providers.

Primary Care Physician

A general practitioner, internist, family practitioner, or pediatrician who handles your health care needs and those of your family. He or she determines the nature and severity of health problems and recommends treatment approaches. A primary care physician not only provides a broad range of preventive and treatment services, but also makes referrals to specialists, or for tests, and integrates the results of these referrals into your overall treatment.

Reasonable and Customary

A schedule, generally based on a survey or formula, of physician fees for specific medical and surgical procedures that are commonly charged in a defined geographic region.

SECTION ONE

ENROLLMENT

A. Cost to Enrollees

Under the City's health benefits program, the basic coverage for some of the health plans requires no member contribution, while others require a payroll or pension deduction. All plans, except for Med-Team, provide additional benefits available through optional benefit riders which may be purchased through payroll or pension deductions. The basic plan and optional rider costs are shown on pages 44 & 45 of this booklet.

B. Who Is Eligible

1. Employees

You are eligible for health coverage and you may enroll in the City Employee Benefits Program if:

- a. You work—on a regular schedule—for at least 20 hours per week;
and
- b. Your appointment is expected to last for more than six months.

2. Retirees

You are eligible for health coverage and you may enroll in the City Employee Benefits Program when you retire if:

- a. You have at least five years of credited service as a member of an approved pension system (this requirement does not apply if you retire because of accident disability);
and
- b. You have been employed by the City (or City-related or City-approved agency) prior to retirement and have worked regularly for at least 20 hours per week;
and
- c. You receive a pension check from a retirement system maintained by the City or another system approved by the City.

NOTE: TIAA/CREF retirees—CUNY retirees who are members of TIAA/CREF have different eligibility rules; consult your institution's personnel office for details.

3. Dependents Eligible for Enrollment

- Legally married husband or wife. An ex-spouse is never eligible for coverage under the Employee Benefits Program regardless of the provisions of any legal settlement.
- Unmarried children under age 19. The term "children" for purposes of this and the following definitions, includes: natural children; children for whom a court has accepted a consent to adopt and for the support of whom an employee or retiree has entered into an agreement; children for whom a court of law has made an employee or retiree legally responsible for support and maintenance; and children who live with an employee or retiree in a regular parent/child relationship and are supported by the employee or retiree.

- Unmarried dependent children—age 19 to 23 who are full-time students.* This applies to all plans except for the hospital coverages of the GHI plans. Empire Blue Cross and Blue Shield hospitalization coverage for full-time students is available only as part of the optional rider on GHI-CBP. It is not available on the GHI Type C plan.

- Unmarried children age 19 and over who cannot support themselves because of mental illness, developmental disability, mental retardation, or physical handicap are eligible for coverage if the disability occurred before their 19th birthday. You must provide medical evidence of the disability. Contact the health plans or your agency personnel or payroll office for the forms which must be completed for continuation of coverage.

4. Double City Coverage Is Not Permitted

You cannot be covered by two health plans for which the City pays or to which the City contributes.

If you are eligible for coverage as an employee or retiree and as a dependent (of another City employee or retiree), you may enroll as an employee (or retiree) or as a dependent, but not both. Eligible dependent children must all be enrolled as dependents of one parent.

If both husband and wife are eligible for City health coverage as either employees or retirees and one is enrolled as the dependent of the other, the person enrolled as a dependent may pick up coverage, at any time, in his or her own name if the other contract is terminated for any reason.

C. How To Enroll

1. As an Employee

To enroll, you must obtain and file an Employee Health Benefits Application (Form EB 88) at your payroll or personnel office. The form must be filed within 31 days of your appointment date (for exceptions, see E.1). If you do not file the form on time, the start of your coverage will be delayed and you may be subject to loss of benefits.

2. As a Retiree—at Retirement

You must file a Retiree Health Benefits Application (Form P2r) at your payroll or personnel office prior to retirement to continue your coverage into retirement.

3. After Retirement

To enroll, you must obtain a Retiree Health Benefits Application (Form P2r) from the Employee Benefits Program. Complete the form and file it with the Employee Benefits Program. You must meet the eligibility requirements described on this page. If you are retired from a cultural institution, library, the Fashion Institute of Technology, or if you receive a TIAA/CREF pension and are eligible for City health coverage, you must file a Retiree Health Benefits Application (Form P2r) with your former employer.

*Empire Blue Cross and Blue Shield HEALTHNET, Mid-Hudson Health Plan and WellCare provide full-time student coverage to age 25.

4. Special Retiree Eligibility

If you have retired but will not receive a City pension check until you become age 55, you may be eligible for up to an additional five years of City-paid health coverage. As the result of a collective bargaining agreement, retirees who are members of the New York City Employees' Retirement System—Pension Plan A—or the Board of Education Retirement System and have had at least 20 years of credited service are eligible for five years of additional City coverage. Please contact your payroll or personnel office for details.

D. Waiver of Health Benefits

If you are already enrolled for City health benefits in any other capacity, for example, as a dependent, or if you do not want City health coverage, you must waive membership in the City Employee Benefits Program by completing the appropriate sections of the Employee Health Benefits Application (Form EB 88). Retirees may waive membership by completing the appropriate sections of the Retiree Health Benefits Application (Form P2r). Every eligible employee or retiree must either enroll for coverage or waive membership.

E. Effective Dates of Coverage

1. When Coverage Begins for Employees

For Provisional employees, Temporary employees, and those Non-Competitive employees for whom there is no experience or education requirement, coverage begins on the first day of the pay period following the completion of 90 days of continuous employment, provided that your Application (Form EB 88) has been submitted within that period.

2. For All Other Employees

For employees appointed from Civil Service eligible lists, Exempt employees, and those Non-Competitive employees for whom there is an experience or education requirement, coverage begins on your appointment date, provided your Application Form has been received by your agency personnel or payroll office within 31 days of that date.

3. For Eligible Dependents

Coverage for eligible dependents listed on your Application Form will begin on the day that you become covered.

Dependents acquired after you submit your Application Form as a result of marriage, birth, or adoption of a child will be covered from the date of marriage, birth, or adoption, provided that you submit the required notification within 31 days of the event (see Changes in Family Status page 5).

4. Late Enrollment

For employees and their dependents, filing an application later than 31 days after the date of the marriage, birth, etc. constitutes a late enrollment. Coverage will begin on the first day of the payroll period following the receipt of the application by the agency payroll or personnel office.

5. When Coverage Begins for Retirees

If you file the proper form for continuation of coverage into retirement with your agency payroll or personnel office prior to retirement (usually 4 to 6 weeks), for most retirees, coverage begins on the day of retirement (see F., Identification Cards).

F. Identification Cards

When you first enroll under the Program, whenever there is a change in family status (e.g. from individual to family) when you transfer from one plan to another, or when you retire, your health plan(s) will issue new identification cards.

Group Health Incorporated subscribers (GHI Type C or GHI-CBP) will receive two identification cards, one from GHI and one from Empire Blue Cross and Blue Shield. The Empire Blue Cross and Blue Shield card should be used for hospital admissions or emergency room visits. The GHI card should be used for physician or other medical services.

Subscribers to all other plans will receive one identification card which should be used for both medical and hospital services.

If you do not receive a new identification card from your health plan(s) within two months after submitting an Application Form, you should notify your agency payroll or personnel office. If you are a retiree, write to the Employee Benefits Program (see Section Thirteen).

During the period from retirement to the issuance of the new identification cards to the retiree, the retiree may receive cancellation notice from his/her plan and a direct payment option. **The retiree should ignore this mailing**, as it is due to a routine delay in updating computer files to reflect retirement status. If the retiree or any of the retiree's dependents, enrolled in an HMO, need services and the identification cards have not been issued to the retiree, the retiree should present the retiree copy of the enrollment form (P2r) to the physician as proof of enrollment. If the retiree belongs to an indemnity program, claims should be held and submitted after the identification cards are received. If hospitalized, the retiree should contact his/her health plan or the Employee Benefits Program for assistance.

G. Optional Benefits Riders

Most of the health plans have an optional rider consisting of various benefits which are not part of the basic plan. You may elect optional benefits rider coverage when you enroll. Optional riders are paid for through payroll or pension deductions. The cost of these riders can be found on pages 44 and 45.

Many employees and retirees are provided with additional health benefits through their welfare funds. If you are enrolled in GHI-CBP/EBCBS, GHI Type C/EBCBS, HIP/HMO* Metropolitan Health Plan, or Med-Plan and your welfare fund is providing benefits similar to some (or all) of the benefits contained in your plan's optional benefits rider those specific benefits will be provided only by your welfare fund and will not be available through your health plan rider. Pension and payroll deductions will be adjusted accordingly. Each rider is a package. You may not select individual benefits in the rider.

The optional benefit rider for Empire Blue Cross and Blue Shield HEALTHNET, HIP CHOICE, WellCare, Mid-Hudson

*If you or your dependents are covered by HIP VIP and other persons on your plan are not Medicare eligible, and your union welfare fund provides prescription drug benefits you do not need to choose optional rider coverage. Benefits for appliances and private-duty nursing will be provided to the non-Medicare eligible person at no cost.

Health Plan, US Healthcare, Sanus/New York Life, and TOTAL HEALTH consists of a prescription drug plan. If your union welfare fund provides prescription drug benefits, **do not choose** the optional benefit rider on these plans. Payroll or pension deductions will not be adjusted automatically to account for union welfare fund benefits.

H. Deductions for Your Optional Benefits Rider

1. From Paychecks

If you apply for an optional benefits rider or if there is a payroll deduction for your plan's basic coverage, your paycheck should show a deduction for this cost. If your check does not reflect the deduction within two months after submitting a new Application Form, or if your deductions are not correct, you must notify your personnel or payroll office.

2. From Pension Checks

It may take considerable time before health plan deductions start from retirees' pension checks. A larger retroactive deduction is then made to pay for the period from retirement to the time of the first deduction.

When retirees in the New York City Employees' Retirement System receive their first full pension allowance checks, their pension numbers change. Because of this, deductions will stop for three to five months and will begin again when the new numbers have been processed. Health coverage is continuous throughout this period. When deductions begin again, they will include back charges for months when deductions were not taken. Advise the New York City Employee Benefits Program in the event that deductions have not resumed after that time or if your deductions are incorrect. When either you or a dependent becomes Medicare eligible (reaches age 65 or becomes eligible through disability), the amount deducted is adjusted after you notify the Employee Benefits Program of Medicare coverage. This adjustment may also take time to be recorded.

3. Incorrect Deductions

If incorrect deduction amounts are being taken from your payroll or pension checks, report the error promptly. Employees should contact their agency benefits representative and retirees should contact the Employee Benefits Program. Corrections will be made as quickly as possible after notification.

SECTION TWO

CHANGES IN ENROLLMENT STATUS

A. Changes in Family Status

Changes in your family status may make it necessary, or desirable, for you to change your type of coverage. Changes in coverage do not happen automatically. You must submit a form requesting the type of change you wish to make. Employees may obtain an Employee Health Benefits Application (Form EB 88) and submit the completed form to their personnel or payroll office. Retirees should obtain a Retiree Health Benefits Application (Form P2r) and submit the completed form to the Employee Benefits Program.

1. Adding or Dropping Dependents

You must complete a form to add dependents due to marriage, birth or adoption of a child, and to drop dependents due to death, divorce, legal separation, or a child reaching

an ineligible age.* Employees should complete an Employee Health Benefits Application (Form EB 88) and retirees should complete a Retiree Health Benefits Application (Form P2r). Forms should be submitted within 31 days of the event. [Late enrollment: see page 4, E.4.] Appropriate documentation of marital status or birth or adoption of a child is required.

2. Child Reaching Age 19 or Age 23

Under a family contract, unmarried dependent children are normally covered to age 19. Unmarried dependent children age 19 to 23 who are full-time students are covered under all plans except for the hospital coverages of the two GHI plans. Empire Blue Cross and Blue Shield hospitalization for full-time students is available as part of the optional rider through GHI-CBP. It is not available on the GHI Type C plan. Coverage for full-time students up to age 25 is provided by Empire Blue Cross and Blue Shield HEALTHNET, Mid-Hudson Health Plan, and WellCare (see page 3 for special provisions for disabled children).

B. Change in Plan

1. Annual Transfer Period

Health Benefits Transfer Periods are usually scheduled once each year. During these periods, all employees may transfer from their current health plan to any other plan for which they are eligible or add optional benefits rider coverage to their present plan. Except for 1989, retirees participate in employee transfer periods that occur in even-numbered years.

If you do not apply for an optional benefits rider when you first enroll, you may obtain these additional benefits only during a transfer period, upon retirement, or if there is a change in your union or welfare fund coverage.

NOTE: For both employees and retirees, the 1989 Transfer Period will take place from May 1 to June 9. All transfer applications must be submitted by June 9, 1989.

Procedures for Health Plan Transfers

Employees

In order to transfer from one plan to another or to add optional benefits rider coverage, you must complete an Employee Health Benefits Application (Form EB 88) which is available from your agency payroll or personnel office or refer to pages 13-15 for the agency listings. This form must be completed and returned to your payroll or personnel office during the annual transfer period.

See your agency payroll or personnel office for the effective date of the change. Once you submit an Application (Form EB 88), the transfer period is over for you and your transfer is irrevocable.

Retirees

Retirees who receive City pension checks and wish to change their choice of health plan may do so by completing the special Retiree Transfer Period Application. This application can be found at the back of this book. It must be returned

*If a covered dependent loses eligibility, that person may obtain benefits through the COBRA Extension of Benefits provisions described on page 7 of this booklet.

to the Employee Benefits Program during this designated transfer period. Retirees of cultural institutions, libraries or the Fashion Institute of Technology, and retirees who receive TIAA/CREF pensions who wish to transfer may also use the application at the back of this book. It must be completed and returned to your former employer for processing.

Retirees may call a special telephone number set up exclusively for 1989 Transfer Period information. The number is (212) 791-1550 and will be staffed during regular business hours only until the end of the 1989 Transfer Period.

All changes made by retirees during the 1989 transfer period will become effective September 1.

2. Additional Retiree Transfer Opportunities

As a result of a collective bargaining agreement, retirees may also transfer or add an optional benefits rider once in their lifetime, at any time during the year, after they have been retired for at least one year. These transfers become effective on the first of the month following the date that the retiree signs the Retiree Health Benefits Application.*

C. Transfer Into or Out of Your Health Plan's Service Area

If you are enrolled in HIP/HMO, HIP-CHOICE, Med-Plan, Med-Team, Empire Blue Cross and Blue Shield HEALTHNET, US Healthcare, Mid-Hudson Health Plan, WellCare, Sanus/New York Life, TOTAL HEALTH, or Metropolitan Health Plan and permanently move outside of your plan's service area, you may transfer within 31 days to another plan without waiting for the next transfer period. Also, if you move inside a service area, you may transfer within 31 days to one of these plans.*

D. Special Leave of Absence Coverage (SLOAC)

Certain employees on maternity or authorized leave without pay as a result of temporary disability or illness, or receiving Workers' Compensation may have their City health coverage continued for certain specified periods of time through the Special Leave of Absence Coverage (SLOAC) provisions. Contact your payroll or personnel office for details.

E. Change of Address

If you change your address be sure to notify your health plan(s) by telephone or in writing so that your records can be up-to-date. Always provide your certificate or identification number when communicating with health plans.

Retirees should notify the Employee Benefits Program of any address change.

*Exception: When transferring into the Medicare Risk Plans (HIP VIP, TOTAL HEALTH, and US Healthcare) transfers will become effective on the first day of the month, three months following the date of authorization indicated on the P2r. For example, if the P2r is completed in August, the effective date would be December 1.

F. Transfer from One City Agency to Another

If you leave the employment of one City agency at which you are covered under the City Employee Benefits Program and subsequently become employed by another City agency at which you are eligible to enroll for health coverage, your coverage will become effective on your appointment date at the new agency, provided that no more than 90 days have elapsed since your coverage terminated at the first agency. Your new agency should reinstate your coverage (see Section Three, paragraph B).

If more than 90 days have elapsed, the rules specified in Section One of this booklet apply. You must complete a new Employee Health Benefits Application (Form EB 88).

SECTION THREE

TERMINATION AND REINSTATEMENT

A. When Coverage Terminates

Coverage terminates:

1. For an employee or retiree and covered dependents, when the employee or retiree stops receiving a pay check or pension check.
2. For a spouse, unless otherwise eligible through the death of the employee or retiree, when divorced or legally separated from an employee or retiree.
3. For a child, upon marriage or reaching an ineligible age, except for unmarried, dependent, full-time students who are covered on all plans** up to age 23 or 25 (see page 3 for special provisions for disabled children and for further information concerning children who reach age 19, 23 or 25).
4. For all dependents, when the City employee or retiree dies.

If both husband and wife are eligible for City health coverage as either an employee or a retiree and one is enrolled as the dependent of the other, the person enrolled as a dependent may pick up coverage in his or her own name if the other leaves City employment or dies.

B. Reinstatement of Coverage

If you have been on leave without pay or have been removed from active pay status for any other reason your health coverage may have been interrupted. Contact your agency payroll or personnel office concerning your health coverage when you return to work.

If your coverage has been terminated for more than 90 days, you must complete a new Employee Health Benefits Application (Form EB 88). Your coverage resumes on the date you return to duty if you complete the form within 31 days of your return to work.

If your coverage has been terminated for less than 90 days, your agency payroll or personnel office will send the appropriate notification to the health plans in order to reinstate your health plan coverage on the date you return to work.

**Empire Blue Cross and Blue Shield hospitalization coverage is only available as part of the optional rider through GHI-CBP. There is no hospital coverage available under GHI Type C.

SECTION FOUR

OPTIONS AVAILABLE WHEN CITY COVERAGE TERMINATES

A. Conversion Options

Each health plan offered by the Employee Benefits Program affords the opportunity for an employee and/or his or her spouse or covered dependents to purchase health coverage on an individual self-paid basis when coverage under the City's group ceases. Unlike COBRA, discussed in "B" below, benefits offered under this type of policy are of an indefinite duration and may vary from the City's "basic" benefits package in both the scope of the benefits and the cost to the individual.

An employee and/or his or her spouse or covered dependent may elect conversion to a direct payment policy when coverage under the City's group ceases for any of the following reasons:

1. The employee (policyholder) leaves City employment;
2. The employee (policyholder) loses City coverage due to a reduction in the work schedule;
3. The employee/retiree (policyholder) dies;
4. A dependent spouse is divorced or legally separated from the employee/retiree (policyholder);
5. Dependent children exceed the age limits established under the group contract; or
6. Coverage under the provisions of COBRA expires. (see "B" for further information).

An individual electing the conversion option must notify the health plan of his/her request for such coverage within 45 days of termination of coverage under the City's group.

For further information on the scope and cost of benefits available, please contact your current health plan.

B. COBRA Continuation Benefits

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), also known as COBRA, was enacted by Congress on April 7, 1986 and implemented by the City of New York on July 1, 1987.

The law requires that the City offer employees, retirees and their families the opportunity to continue group health and/or welfare fund coverage at 102% of the group rate in certain instances where the coverage would otherwise terminate. All group benefits, including optional benefits riders, are available. Welfare fund benefits which can be continued under COBRA are dental, vision, prescription drugs, and other related medical benefits. The period of coverage varies from 18 to 36 months, depending on the reason for continuation.

1. Eligibility

Employees of the City of New York are eligible for continuation under COBRA if their health and welfare fund coverages are terminated due to a reduction in hours of employment or the termination of employment (for reasons other than gross misconduct). Termination of employment includes unpaid leaves of absence of any kind.

Spouses of employees (or retirees) have the right to choose continuation of coverage if they lose coverage for any of the following reasons: 1) death of the City employee or retiree; 2) termination of the employee's City employment (for reasons other than gross misconduct); 3) loss of health coverage due to a reduction in employee's hours of employment; 4) divorce or legal separation from the City employee (or retiree); 5) loss of coverage under COBRA when a contract holder becomes Medicare eligible; 6) retirement of the employee (see **Retirees** below).

Dependents of employees or retirees have the right to continue coverage if coverage is lost for any of the following reasons: 1) death of a parent (the City employee or retiree); 2) the termination of a parent's employment (for reasons other than gross misconduct); 3) loss of health coverage due to the parent's reduction in hours of employment; 4) loss of coverage under COBRA when a contract holder becomes eligible for Medicare; 5) the dependent ceases to be a "dependent child" under the terms of the Employee Benefits Program; 6) retirement of the covered parent (see **Retirees** below).

Retirees and the families of retirees whose welfare fund benefits are reduced or terminated at the time of retirement are eligible to continue benefits under the welfare fund as COBRA enrollees. The cost is 2% above the welfare fund group rate. Contact your welfare fund for premium amounts and benefit availability.

NOTE: Individuals covered under another group plan or eligible for Medicare are not eligible for COBRA continuation for health benefits. However, these people are able to purchase certain welfare fund benefits. For more information, contact the appropriate welfare fund.

2. Periods of Continuation

Continuation of coverage for the former employee, retiree and family as a result of termination of employment (for reasons other than gross misconduct), reduction of work schedule, or loss of welfare fund benefits due to retirement is available for a maximum period of 18 months.

Continuation of coverage for the spouse or dependent as a result of death, divorce, legal separation, losing coverage due to Medicare eligibility of the contract holder, or loss of dependent child status is available for a maximum of 36 months.

Continuation of coverage can never exceed 36 months in total, irrespective of the number of events which relate to a loss in coverage.

Coverage during the continuation period will terminate if the enrollee fails to make timely premium payments or becomes enrolled in another group health plan or becomes eligible for enrollment in Medicare.

3. Notification Responsibilities

Under the law, the employee or family member has the responsibility to notify the City agency payroll or personnel office and the applicable welfare fund within 60 days of an address change, death of employee, divorce, legal separation, or a child losing dependent status. Retirees and/or the family members must notify the Employee Benefits Program and the applicable welfare fund within 60 days in the case of death of the retiree or the occurrence of any of the aforementioned events.

When a qualifying event (such as an employee's death, termination of employment, or reduction in hours) occurs, you and your family will be notified by your City agency of your option to choose continuation coverage.

4. Transfer Opportunities

Former employees and dependents who opt for COBRA continuation are entitled to the same benefits and rights as employees. Therefore, COBRA enrollees may take part in the annual transfer period. Dependents of retirees enrolled in COBRA continuation coverage will continue to receive the same transfer opportunities available to retirees: once-in-a-lifetime transfer (if not already used), and transfer during the normal transfer period for retirees.

COBRA eligibles may also transfer when a change of address allows or eliminates access to a health plan which requires Zip Code residency for eligibility.

Application forms to be used during the transfer period should be obtained from the COBRA enrollee's current health plan. Applications should be returned to the current health plan which will forward enrollment information to the new plan. For those electing Sanus/New York Life, WellCare, or TOTAL HEALTH, please fill in the name of the plan in the space called "Other." Be sure to elect a primary care physician for each family member. These transfers will become effective on September 1, 1989.

City agencies will not in any way handle COBRA enrollee transfers, nor will they process any future changes such as adding dependents. All future transactions will be handled by the health plan in which the COBRA eligible is enrolled.

5. Election of COBRA Continuation

To elect COBRA continuation of health coverage, the COBRA eligible person must complete a "COBRA—Continuation of Coverage—Application." Employees and/or eligible family members can obtain an application form from their agency payroll or personnel office. Retirees' eligible family members can obtain an application form by contacting the Employee Benefits Program. Please contact the applicable welfare fund if you wish to purchase its benefits.

Eligible persons choosing to elect COBRA continuation coverage must do so within 60 days of the date on which they receive notification of their rights. Premium payments will be made on a monthly basis. The first premium payment must accompany the application for COBRA continuation and must be sent to the applicable health plan. Subsequent payments will have a 30-day grace period.

C. New York State Six-Month Extension

The New York State Six-Month Extension applies only to employees terminated for reasons of gross misconduct, enrolled in an indemnity plan (e.g., the GHI plans), and who were hired on or after January 1, 1986.

Employees terminated for reasons of gross misconduct can elect to continue their GHI and Empire Blue Cross and Blue Shield coverage for a period of up to six months on a self-paid basis at a cost of 100% of the group rate.

To elect coverage under the Six-Month Extension, a terminated employee must complete a Six-Month Extension (Form EB 6) and return the appropriate copies of the application to GHI and Empire Blue Cross and Blue Shield along with the first premium payments within 31 days of termination.

Payments for the extension of coverage are made quarterly. Each carrier is paid separately for the coverage it provides. (GHI provides medical coverage and Empire Blue Cross and Blue Shield provides hospitalization coverage.)

D. Lay-off Legislation

New York State Law has authorized the State Insurance Fund to administer a program to assist laid-off workers (when the lay-off affects 50 or more City employees) in the payment of their health plan premiums.

The program will provide up to four months premium or \$500 (whichever is reached first) toward the payment of health plan premiums.

If there are massive lay-offs, you will be further informed of your right to this benefit.

E. Disability Benefits

If on the date of termination you are totally disabled as a result of an injury or illness, you remain covered with respect to your disability up to a maximum of 18 additional months for the GHI-CBP plan and up to 12 months for the HMO plans. GHI Type C provides only 31 days of additional coverage. This extension of benefits applies only to the disabled person and only covers the disabling condition. Under the GHI plans, if a subscriber is hospitalized at the time of termination, hospital coverage (under Blue Cross) is extended only to the end of the hospitalization. Contact your health plan for details.

SECTION FIVE

CITY COVERAGE FOR MEDICARE ELIGIBLE RETIREES

**(This does not apply to employees over age 65.
See Section Six.)**

When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare. The City's Employee Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. In order to maintain maximum health benefits, it is essential that you join Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) at your local Social Security Office as soon as you are eligible. If you do not join Medicare, you will lose whatever benefits Medicare would have provided. The City's Employee Benefits Program supplements Medicare but does not duplicate benefits which are available under Medicare. Medicare eligibles must be enrolled in Medicare Parts A and B in order to be covered by Med-Team, Empire Blue Cross and Blue Shield HEALTHNET, US Healthcare, TOTAL HEALTH, WellCare, Mid-Hudson, or Sanus/New York Life. Medicare eligible retirees enrolled in HIP/HMO must maintain Medicare Part B coverage or lose their HIP/HMO membership. Medicare eligibles may not be enrolled in Med-Plan or Metropolitan Health Plan. If covered by HIP VIP, TOTAL HEALTH, or US Healthcare, Medicare eligible members will not receive health benefits if care is received outside of their plans.

A. Medicare Enrollment (Retirees Only)

To enroll in Medicare and assure continuity of benefits upon becoming age 65, contact your local Social Security Office during the three-month period before your 65th birthday.

In order not to lose benefits, you must enroll in Medicare during this period even if you will not be receiving a Social Security check.

If you are over 65 or eligible for Medicare due to disability and did not join Medicare, contact your Social Security Office to find out when you may join. If you do not join Medicare Part B when you first become eligible, there is a ten percent higher premium for each year you were eligible but did not enroll. In addition, under certain circumstances there may be up to a fifteen-month delay before your Part B coverage can begin upon re-enrollment.

If you, or your spouse, are INELIGIBLE for Medicare Part A or Parts A and B, although over age 65—(reasons for ineligibility include non-citizenship or residence outside of the U.S.A. or its territories for Parts A and B, or non-eligibility for Social Security benefits for Part A), apply to:

**N.Y.C. Employee Benefits Program
110 Church Street—12th Floor
New York, N.Y. 10007**

A Non-Medicare Eligible Policy can be provided for persons on certain health plans. Under a Non-Medicare Eligible Policy, you will continue to receive under-65 hospital and/or medical benefits even though you are over 65.

Please provide full identifying information, including name, date of birth, address, agency from which retired, pension number, health plan and certificate numbers, health code, Social Security Number and Medicare number (if any). Also give the reason for ineligibility for Medicare Part A and/or Part B.

If you are eligible for Medicare Part B as a retiree but neglect to file with the Social Security Office during their enrollment period (January through March) or prior to your 65th birthday, you will receive supplemental medical coverage only. You cannot receive the Non-Medicare Eligible Policy.

B. Notification to the Employee Benefits Program and Health Plans

You must notify the Employee Benefits Program in writing three to four months before you or a dependent joins Medicare. Include the following information: Identification card number, Medicare number(s), Medicare effective date(s) and birthdates for yourself and spouse, retirement date, pension number and pension system, name of health plan, name of union welfare fund. In some cases, the Employee Benefits Program or your health plan may contact you requesting some of this information. Once the Employee Benefits Program is notified that you are covered by Medicare, deductions from your pension check will be adjusted if applicable and you will automatically receive the annual Medicare reimbursement (see D., Medicare Reimbursement). The Employee Benefits Program will notify your health plan that you are on Medicare so that your benefits can be adjusted. This may take several months. If your plan does not accept Medicare eligibles, you will receive special instructions concerning changing to another health plan.

C. Medicare Catastrophic Coverage Act

Effective January 1, 1989, the Medicare Catastrophic Coverage Act of 1988 provides certain new Medicare benefits and improves several existing benefits. The new benefits provided are as follows:

- a. Medicare hospital insurance (Part A):
Unlimited hospitalization for approved care with a single annual deductible (\$560 in 1989).
- b. Skilled nursing facility care:
Medicare will pay for up to 150 days of skilled care per calendar year in a Medicare-certified skilled nursing facility. There will be a co-payment for the first eight days of care.
- c. Hospice care benefits for the terminally ill.

Effective January 1, 1989, all deductibles and co-insurance amounts not covered by Medicare Part A are covered by Blue Cross through your basic City-paid hospital coverage. The optional 365-day Blue Cross hospital riders for GHI-CBP/Blue Cross and GHI Type C/Blue Cross were eliminated for those covered by Medicare, as they would duplicate benefits now provided by Medicare.

As all other City health plans covering Medicare-eligible retirees provide unlimited hospitalization, there is no change in benefits as a result of the new law.

Effective January 1, 1990, new benefits will be provided as follows:

- a. Home health care benefits.
- b. \$1,370 per year limitation on Medicare Part B co-insurance costs.
- c. Prescription drug benefit phased in from 1990 to 1993.
- d. Respite care benefit.
- e. Mammography benefit.

For 1989 and 1990 only, the City Employee Benefits Program, in compliance with the maintenance of effort provision of the law, will adjust its benefit provisions to eliminate benefits which duplicate those provided by Medicare and will return the value of those benefits to City retirees in accordance with Federal Law and regulations.

You will receive further notification in 1989 relating to this provision of the law.

D. Medicare Reimbursement

The City will reimburse you for a portion of the monthly premium for Medicare Part B for yourself and your spouse and dependents enrolled on Medicare disability.

Periodically, the Medicare Part B premium is increased by the Social Security Administration. At the time of each increase, legislation must be approved by the City Council authorizing the City to reimburse you at a new rate. 1988 reimbursements will be paid at the rate of \$19.53 per month and for 1989 reimbursements will be paid at the rate of \$27.90 per month.

If you are receiving a Social Security check, the premium will be deducted from that check monthly. If you are not receiving a Social Security check, you will be billed on a quarterly basis by the Social Security Administration.

You must be receiving a City pension check and be enrolled as the contract holder for City health benefits in order to receive reimbursement for Part B premiums. For most retirees, beginning in 1989, the refund is issued automatically by the Employee Benefits Program, Medicare Reimbursement Unit (110 Church Street, 12th Floor, New York, New York 10007, telephone 212-385-1378). Medicare Part B reimbursement checks are generally issued once a year in the summer following the year in which premiums are paid.

SECTION SIX

SPECIAL PROVISIONS FOR MEDICARE ELIGIBLE EMPLOYEES

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, the Deficit Reduction Act of 1984 (DEFRA), the Consolidated Omnibus Budget Reconciliation Acts of 1985 (COBRA) and 1986, and the Omnibus Budget Reconciliation Act of 1986 (OBRA) enacted by the Federal Government, contain provisions that directly affect your City group health benefit.

They require the City of New York to offer all employees or their dependents over age 65 or covered by Medicare through the Special Provisions of the Social Security Act for the Disabled* the same health coverage offered to employees not yet age 65 and under the same conditions. Your City health plan will automatically become your primary coverage and Medicare will provide secondary coverage.

If you wish Medicare to be your primary coverage, you are not eligible for the City's group health plan. You must complete the waiver section of the Employee Health Benefits Application (Form EB 88) and return it to your agency payroll or personnel office.

A. Retirement

At retirement, employees who have chosen Medicare as their primary plan or whose dependents have not been covered on their plan because their spouse elected Medicare as the primary plan may re-enroll in the City health program. This is done by completing a Retiree Health Benefits Application (Form P2r) and submitting it to their payroll or personnel office.

Also at retirement, employees for whom the City health plan had provided primary coverage for Medicare eligibles are permitted to change health plans effective on the same date as their retiree health coverage.

B. Medicare Reimbursement

Employees and their dependents covered by Medicare will now have identical benefits to those provided to employees and their dependents under age 65. Because of the cost of these benefits, the City does not reimburse employees or dependents for their Medicare Part B premiums if the City health plan is primary. (Employees or their dependents who elect Medicare as their primary coverage and waive

*The rules are somewhat different for persons eligible for Medicare due to end-stage renal disease. Consult your Medicare Handbook or agency health benefits representatives for further information.

or cancel City health plan benefits are entitled to reimbursement of Medicare Part B premiums.)

Medicare reimbursement will be available at retirement when Medicare becomes the primary plan.

C. Medicare Enrollment

Medicare Medical Insurance (Part B) is voluntary with a monthly premium which is subject to change. If you and/or your dependents choose City health coverage as primary, Medicare will be supplementary to any City health plan.

There are no penalties for late enrollment in Medicare Part B if employees choose the City Health Benefits Program as primary coverage and cancel or delay enrollment in Medicare Part B coverage until retirement or termination of employment, when Medicare enrollment is permitted for a limited period of time. Medicare Hospital Insurance (Part A) should be maintained. For most persons, Part A coverage is free.

SECTION SEVEN

NYC HEALTHLINE

NYC HEALTHLINE is a managed care program which was developed by the Employee Benefits Program and the City's Municipal unions. City employees, non-Medicare eligible retirees and covered dependents who are members of either GHI plan (GHI-CBP or GHI Type C) and reside in the tri-state New York New Jersey, Connecticut area have had NYC HEALTHLINE as part of their benefits since December 1, 1986. If you or a member of your family is scheduled for certain office surgery, ANY outpatient surgery at a hospital or surgi-center, or ANY hospital admission (surgical, maternity, medical, pediatric or psychiatric) you MUST call NYC HEALTHLINE before the surgery or admission to maintain your full health plan benefits. With the help of qualified health care professionals, NYC HEALTHLINE can help you make important health care decisions in managing your treatment and getting the most for your health care dollar.

The telephone numbers for NYC HEALTHLINE can be found on your Empire Blue Cross and Blue Shield and GHI identification cards. After July 1, 1989 dial only the toll-free "800" number printed on your identification cards, or the new toll-free number in place as of July 1, 1989, 1-800-521-9574. The local telephone numbers will be discontinued.

Who Must Call NYC HEALTHLINE?

You MUST call NYC HEALTHLINE IF:

- You are a member of GHI-CBP/EBCBS, or GHI Type C/EBCBS plans,

AND

- You are a City employee, or a City retiree who is NOT eligible for Medicare, or you are purchasing City coverage directly under COBRA continuation,

AND

- You are a resident of the New York, New Jersey, Connecticut tri-state area,

OR

- You are a dependent (under 19 years old) or spouse of such an employee or retiree.
- GHI health plan is your primary coverage.

DO NOT CALL NYC HEALTHLINE FOR GHI CLAIMS OR MEMBERSHIP PROBLEMS.

Why Must You Call NYC HEALTHLINE?

A. TO HELP YOU MAKE INFORMED DECISIONS ABOUT YOUR OWN HEALTH CARE. In most cases, your Care Coordinator will approve your plan of care immediately, and pre-certify it for payment. In other cases, alternatives may be available to you. Depending on your medical problem, you might benefit from a second surgical opinion, ambulatory surgery, pre-admission testing, or early discharge with home care. All you have to do is to remember to CALL NYC HEALTHLINE.

B. TO PRESERVE YOUR FULL HEALTH BENEFITS AND AVOID PENALTIES. It is your responsibility to call NYC HEALTHLINE, for any hospital admission. If you go ahead with a hospital admission or certain office procedures without first calling NYC HEALTHLINE, your coverage will be reduced in one of two ways:

1. For any hospital admission or ambulatory surgery in a hospital facility or a surgi-center, your Empire Blue Cross and Blue Shield coverage will be reduced by \$250 per day up to a total of \$500, and YOU will be responsible for that amount.
2. For certain procedures performed in a doctor's office (any surgery of the foot, nose, eye, tonsils, adenoids, breast, knee, or varicose veins, and any procedure to correct a hernia), your GHI coverage will be reduced by \$500 or 50% (whichever is less), and YOU will be responsible for that amount.

When Must You Call NYC HEALTHLINE?

You **MUST** call NYC HEALTHLINE when:

- Your doctor schedules a hospital admission for you or a covered family member,
 - For maternity admissions, as soon as the delivery date is known,
- OR
- Your doctor schedules any outpatient surgical procedure at a hospital facility or surgi-center,
- OR
- Your doctor schedules any of the procedures listed above in his or her office.

SOME IMPORTANT HEALTHLINE TIPS TO ALWAYS REMEMBER:

- You do NOT have to call NYC HEALTHLINE if the City policyholder has Medicare or lives outside of the tri-state area.
- If you are told to get a second surgical opinion, you **MUST** get it from one of the three specialists recommended by your Care Coordinator. After the second opinion is received, you **MUST** call NYC HEALTHLINE to inform them as to whether or not you will go ahead with the procedure. If you decide to go ahead with the surgery, it will be pre-certified during that phone call. To receive your full benefits, you must have this pre-certification. When directed by NYC HEALTHLINE that a second surgical opinion is required, DC37 members may avail themselves of the Union-sponsored Second Surgical Opinion Program.

SECTION EIGHT

COORDINATION OF BENEFITS (COB)

A. General

You may be covered by two or more group health benefit programs. These programs may provide similar benefits. Should you have services covered by more than one program, the City health carriers will coordinate benefit payments with the other program. In this case, one program pays its full benefit as a primary benefit. The other program pays secondary benefits. This prevents duplicate payments and overpayments. In no event shall payments exceed 100% of a charge.

In order to determine which program is primary, certain rules have been established. The City program follows these rules. These rules apply whether or not you make a claim under both programs.

B. Rules of Coordination

The rules for determining primary and secondary benefits are as follows:

1. The program covering you as an employee is primary before a program covering you as a dependent.
2. When a plan and another plan cover the same child as a dependent, the child's coverage will be as follows:
 - The benefits of the plan of the parent whose birthday falls earlier in the year provides primary coverage.
 - If both parents have the same birthday, the plan which has covered one of the parents longer is primary.
 - If the other plan has a gender rule (the plan covering you as a dependent of a male employee is primary before a plan covering you as a dependent of a female employee), the rule of the other plan will determine which plan will cover the child. (See below for special rules concerning dependents of separated or divorced parents.)
3. If no other criteria apply, the program covering you the longest is primary. However, the program covering you as a laid-off or retired employee, or as a dependent of such a person, shall be secondary and the program covering you as an active employee shall be primary, as long as the other program has a COB provision similar to this one.

C. Special Rules for Dependents of Separated or Divorced Parents

If two or more plans cover a dependent child of divorced or separated parents, benefits are to be determined in the following order:

1. The plan with the parent who has custody of the child is primary.
2. If the parent with custody of a dependent child remarries, that parent's program is primary. The step-parent's program is secondary and the program covering the parent without custody is tertiary.

3. If the specific decree of the court states one parent is responsible for the health care of the child, the benefits of that plan are determined first.

D. Effect of Primary and Secondary Benefits

1. Benefits under a program that is primary are calculated as though other coverage did not exist.
2. Benefits under a program that is secondary are calculated based upon the difference between what the primary program paid and 100% of the actual charge. The amount paid may not exceed the amount that would have been paid in the absence of other coverage.

SECTION NINE

NO-FAULT EXCLUSION

The Employee Benefits Program will not provide benefits for any services for which benefits are available under a No-Fault Automobile Policy.

SECTION TEN

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The City of New York's network of Employee Assistance Programs (EAPs) is staffed by professional counselors who can help employees and their eligible dependents handle an array of problems such as stress, alcoholism, drug abuse, and family problems. EAP means education, information, counseling and individualized referrals to assist with a wide range of personal or social problems. If you don't have an EAP in your own agency or union, you can get help at the Central Employee Assistance Program Referral Unit. The Unit is located at 280 Broadway, Room 426, New York, New York 10007. Telephone numbers are (212) 566-0103 or (212) 566-0104.

The City of New York's Central Employee Assistance Program gives you free, personal and quick access to referrals for professional help.

An employee's contact with this service is private, privileged and strictly confidential. No information will be shared with anyone at any time, without your written consent.

SECTION ELEVEN

THE EMPLOYEE BLOOD PROGRAM

Your health plan covers the cost of administering transfusions and pays blood processing fees for employees, retirees and eligible family members. It does not pay for the storage of your own blood for future use.

Blood replacement fees are not covered by any health plan offered by the City. However, under the blood supply system introduced in 1980, hospitals in the Greater New York region generally have access to sufficient voluntarily donated blood and therefore do not bill for replacement fees. The Greater New York region comprises New York City, Long Island, nearby counties in upstate New York, and some parts of northern New Jersey. Outside that area, many hospitals, at this writing, are still charging for blood that is not replaced.

To help our community maintain the blood reserves required to avoid resumption of replacement fees, the Employee Blood Program sponsors a voluntary donor program for City employees, called the City Donor Corps. City Donor Corps members who donate once a year are entitled to certain benefits for themselves and family members. For further information, see your agency Blood Program Coordinator, or call (212) 566-2800.

SECTION TWELVE

RECENT BENEFIT CHANGES

HIP for Florida residents—Current enrollees and those newly electing HIP coverage will be provided with medical care through the HIP/HMO Medicare Supplemental Program (MSP). Under this program enrollees may continue to use the services of HIP and will retain the use of their Medicare card outside HIP. More information is available in the HIP sections of this booklet.

GHI-CBP/EBCBS

Effective 1/1/89:

1. Office visit co-pay for participating doctors increases from \$5 to \$8.
2. Major Medical deductible increases from \$100 for an individual and \$300 for a family to \$135 for an individual and \$400 for a family.
3. Emergency room co-payment of \$25 per use of the emergency room not followed by an in-patient hospital admission.

Effective 7/1/89:

1. GHI-CBP Medicare supplemental benefits will be improved and will exactly duplicate the benefits now provided to GHI Type C Medicare enrollees. This level of benefits will be referred to as GHI/Empire Blue Cross and Blue Shield Senior Care. Benefits for non-Medicare eligible retirees and for employees and their spouses are not affected. The prescription and maintenance drug rider available under the GHI Type C program will also be available to GHI-CBP Medicare enrollees under Senior Care. GHI-CBP enrollees will receive instructions through the mail explaining how this drug rider will be provided, and how it may be obtained. See page 16 for descriptions of these benefits.
2. Catastrophic deductible, presently at \$6,000, will be reduced to \$4,000.
3. Coverage for annual diagnostic mammograms for women age 50 and over.
4. GHI's payments to participating providers will be increased.
5. Well-baby care (out of hospital, maximum 5 visits before age one), which is now in the optional rider, will be a basic benefit at no cost to subscriber.
6. The 30 day in-patient rehabilitation benefit for alcoholism under the optional rider will include drug rehabilitation.

Effective 1/1/90:

1. The rider will include a new benefit providing for an average 50% increase in the existing major medical schedule for in-hospital and related procedures.
2. The \$250 co-insurance cap will be increased to \$500 under the optional rider.

Effective 7/1/90:

1. GHI's payments to participating providers will be further increased.

Sanus/New York Life Health Plan—Effective December 1, 1988, Sanus/New York Life Health Plan acquired Maxicare, New York. All Maxicare members residing in the Sanus/New York Life service area will be transferred into Sanus/New York Life effective July 1, 1989.

Maxicare—Effective July 1, 1989, Maxicare Health Plan will no longer be available to New York City employees and retirees. These enrollees will automatically be enrolled in Sanus/New York Life, but may select a new plan during the Transfer Period.

TOTAL HEALTH—Effective July 1, 1989, TOTAL HEALTH will be available to non-Medicare eligible employees and retirees residing in New Jersey.

Medicare Catastrophic Coverage Act of 1988—Effective January 1, 1989 this Act provides new Medicare benefits and improves certain existing benefits. The new benefits are described on page 9.

SECTION THIRTEEN

IF YOU NEED ASSISTANCE

Retirees

Retirees with questions relating to benefits, services, or claims should write or call their health plan at the address given either in this booklet or the appropriate plan booklet. When writing to the Plan, give your Social Security Number, Certificate Number, if different, Group Number, name and address. The Employee Benefits Program is also available to provide service and information to City **retirees** who have questions about or problems with their health benefits or pension check deductions. Retirees writing to the Employee Benefits Program should always include the following information:

- name of health plan
- certificate number/identification number

- Medicare numbers
- names and dates of birth of yourself and your dependents
- your telephone number, pension number and pension system
- the name of the City agency from which you retired
- your last Civil Service Title
- the name of your union or welfare fund (if any)
- the health code or the amount currently being deducted from your pension check
- date of retirement.

The address and telephone number of the Employee Benefits Program appear below:

City of New York
Employee Benefits Program
110 Church Street—12th Floor
New York, N.Y. 10007
Phone: Health Benefits (212) 385-1360
Medicare Reimbursement (212) 385-1378

Retirees may call a special telephone number set up exclusively for 1989 Transfer Period information. The number is (212) 791-1550 and will be staffed during regular business hours only until the end of the 1989 Transfer Period.

Employees

Employees may direct questions concerning enrollment or pay-check deductions to, or obtain enrollment forms (EB88) from, their worksite agency personnel or payroll office. If assistance is not available at your worksite, please refer to the listing below for your agency health benefits office telephone number. Employees with questions relating to benefits, services, or claims should write or call their health plan at the address given in either this booklet or the appropriate plan booklet. When writing to a plan, give your Social Security Number, certificate number (if different), group number, name, and address.

Agency Benefits Representatives (for employees only. Retirees, see above.)

CITY AND CITY-RELATED AGENCIES

Addiction Services Agency
(See Health, Dept. of)

Aging, Dept. for the
(212) 577-8482

Air Resources, Dept. of
(See Environmental Protection
Administration)

Art Commission
(See Mayor, Office of the)

Borough President – Bronx
(212) 590-3531

Borough President – Brooklyn
(718) 643-2066

Borough President – Manhattan
(212) 669-8006

Borough President – Queens
(718) 520-3213

Borough President – Staten Island
(718) 390-5182

NYC Dept. of Buildings
(212) 312-8258

Chief Medical Examiner
(See Health, Dept. of)

City Clerk
(212) 669-8097

City Council, Office of the
(212) 566-7227

City Council, President of the
(212) 669-7652

City Planning, Dept. of
(212) 720-3656

City Record
(See General Services, Dept. of)

City Register
(See Finance Administration)

City Sheriff
(212) 374-8228

City University of New York
(See separate listing)

Collective Bargaining, Office of
(212) 618-8212

Commerce & Industry, Dept. of
(See Economic Development Admin.)

Community Assistance Unit
(212) 566-1465

Comptroller, Office of
(212) 669-7792

Computer Data Communications
Services Agency
(212) 240-4320

Consumer Affairs, Dept. of
(212) 566-5507, 5508

Correction, Board of
(212) 964-6307

Correction, Dept. of
(212) 374-7628

Cultural Affairs, Dept. of
(212) 974-1150

Cultural Institutions
(See separate listing)

District Attorney – Bronx
(212) 590-2538

District Attorney – Kings County
(718) 802-2996

District Attorney – N.Y. County
(212) 553-8847

District Attorney – Queens County
(718) 520-5539

District Attorney – Richmond County
(718) 390-2635

Economic Development, Office of
(212) 513-6317

Education, Board of
(718) 935-2312

Elections, Board of
(212) 924-1932

Department of Employment
(212) 433-3876

Environmental Protection
(212) 566-8370

Estimate, Board of
(212) 669-4512

Ethics, Board of
(212) 566-4900

Ferry & General Aviation Operations,
Bureau of
(See Dept. of Transportation)

Finance, Dept. of
(212) 669-4457

Financial Information Services Agency
(212) 206-3261

Fire Dept., (Uniformed Forces)
(718) 403-1586

Fire Dept., (Non-Uniformed)
(718) 403-1587

Firearms Control Board
(212) 374-5550

Franchises, Bureau of
(212) 669-4500

General Services, Dept. of
(212) 669-7265

Handicapped, Office for the
(See Mayor, Office of the)

Health Dept., Office of Administration
(212) 566-6624

Health & Hospitals Corporation
(See separate listing)

Higher Education, Board of
(See City University of N.Y.)

Highways, Dept. of
(See Transportation, Dept. of)

Housing Authority
(212) 306-3895

Housing, Preservation & Development
(212) 566-7546, 7695

Human Resources Administration
(212) 553-3555

Human Rights, Commission on
(212) 566-0226, 0221

Investigation, Dept. of
(212) 825-2162

Juvenile Justice, Dept. of
(212) 925-7779, ext. 307

Law Department
(212) 566-8695

Licenses, Dept. of
(See Consumer Affairs, Dept. of)

Management & Budget, Office of
(212) 669-2173

Markets, Dept. of
(See Consumer Affairs, Dept. of)

Mayor, Office of the
(212) 566-5054

Mayor's Office of Special Events
(See Mayor, Office of the)

Mental Health & Retardation Services
(212) 431-3731

Municipal Broadcasting System
(See General Services, Dept. of)

Municipal Labor Relations, Office of
(212) 618-8342

Municipal Reference Library
(See General Services, Dept. of)

N.Y.C. Employees' Retirement System
(212) 566-4548

Off Track Betting Corp.
(212) 704-5883

Parking Violations Bureau
(See Transportation, Dept. of)

Parks & Recreation, Dept. of
(212) 830-7771

Payroll Administration, Office of
(212) 669-4840

Personnel, Dept. of
(212) 566-8746

Police Department
(212) 374-7654

Ports International Trade & Commerce
(212) 806-6767

Probation, Office of
(212) 374-3796

Public Works, Dept. of
(See General Services, Dept. of)

Purchase, Dept. of
(See General Services, Dept. of)

Real Estate, Dept. of
(See General Services, Dept. of)

Real Property Assessment, Dept. of
(See Finance Administration)

Records & Information Services,
Dept. of
(212) 566-4292

Rehabilitation Mortgage Ins. Corp.
(212) 425-9351

Sanitation, Dept. of
(212) 815-9867

Social Services, Department of
(See Human Resources Administration)

Special Narcotics Court
(212) 815-0526

Standards & Appeals, Board of
(212) 807-3732

Tax Collection, Dept. of
(See Finance Administration)

Tax Commission
(212) 669-4419

Taxi & Limousine Commission
(212) 382-9305, 9306

Teachers' Retirement System
(212) 566-6654

Traffic, Dept. of
(See Transportation, Dept. of)

Transit Authority
(718) 330-4220

Transportation, Dept. of
(212) 566-0788

Treasury, Dept. of
(See Finance Administration)

Water Resources, Dept. of
(See Environmental Protection Admin.)

Youth Bureau
(718) 403-5393

THE CITY UNIVERSITY OF NEW YORK

Bernard M. Baruch College
(212) 505-5836

Borough of Manhattan Community Colleg
(212) 618-1589

Bronx Community College
(212) 220-6034

Brooklyn College
(718) 780-4255

Central Office

City University of New York
(212) 794-5336

City College
(212) 690-4226, 4227

College of Staten Island
(718) 390-7842

LaGuardia Community College
(718) 482-5075

Graduate School & University Center
(212) 642-2622

Herbert H. Lehman College
(212) 960-8437

Hostos Community College
(212) 960-1096

Hunter College
(212) 772-4512, 4516, 4517

John Jay College
(212) 237-8517

Kingsborough Community College
(718) 934-5436
Medgar Evers College
(718) 270-4995
N.Y.C. Technical College
(718) 643-2986
Queens College
(718) 520-7484
Queensborough Community College
(718) 631-6269
York College
(718) 262-2137

HEALTH and HOSPITALS CORPORATION

Bellevue Hospital Center
(212) 561-4063
Bird S. Coler Memorial Hospital
(212) 848-6339
Bronx Municipal Hospital
(212) 430-5816
Brooklyn Central Laundry
(718) 735-3993
City Hospital Center at Elmhurst
(718) 830-2541
Coney Island Hospital
(718) 615-4748
Cumberland Family Care Center
(718) 403-0821, 0822, 0823
Emergency Medical Service
(718) 326-0600, Ext. 395
Goldwater Memorial Hospital
(212) 750-6942
Gouverneur Hospital
(212) 238-7639
Harlem Hospital Center
(212) 491-1836, 1838
Health and Hospitals Corporation
(212) 566-2990, 8006

Health & Hospitals Corporation, Helpline
(212) 391-4719
Kings County Hospital Center
(718) 735-3165
Lincoln Medical & Mental Health Center
(212) 579-5195
Metropolitan Hospital Center
(212) 230-7349
Morrissania Family Care Center
(212) 960-2744
Neponsit Health Care Center
(718) 474-1900, Ext. 218
North Central Bronx Hospital
(212) 519-3557
Nurse Referrals (H.H.C.)
(212) 840-5228
Queens Hospital Center
(718) 990-2541
Sea View Hospital and Home
(718) 317-3000
Sydenham Family Care Center
(212) 932-6567
Woodhull Hospital
(718) 963-8276

CULTURAL INSTITUTIONS and LIBRARIES

American Museum of Natural History
(212) 769-5105
Brooklyn Botanical Garden & Arboretum
(718) 622-4433, Ext. 327
Bronx County Historical Society
(212) 881-8900
Bronx Museum of the Arts
(212) 681-6000
Brooklyn Academy of Music
(718) 636-4105
Brooklyn Children's Museum
(718) 735-4400

Brooklyn Museum
(718) 638-5000
Brooklyn Public Library
(718) 780-7764
El Museo del Barrio
(212) 831-7272
Fashion Institute of Technology
(212) 760-7699
Hall of Science of the City of New York
(718) 699-0005
Jamaica Arts Center
(718) 658-7400
Museum of the City of New York
(212) 534-1672
New York Botanical Garden
(212) 220-8744
New York Public Library
(212) 704-8672
New York Zoological Society
(212) 220-5126
Queens Borough Public Library
(718) 990-0787
Queens Botanical Garden
(718) 886-3800
The Queens Museum
(718) 592-2405
Snug Harbor Cultural Center
(718) 448-2500, ext. 14
Staten Island Children's Museum
(718) 273-2060
Staten Island Historical Society
(718) 351-1617
Staten Island Institute of Arts & Sciences
(718) 727-1135
Staten Island Zoological Society
(718) 442-3101
Wave Hill Center for Environmental Studies (Perkins Garden)
(212) 549-3200

NOTICE

AS REQUIRED UNDER INTERNAL REVENUE CODE, SECTION 89
The Employee Benefits Program and its constituent health plans are maintained for the exclusive benefit of qualified public employees and retirees and their dependents in the City of New York. The Program and Plans were established, pursuant to applicable law and regulation (including, but not limited to, the New York City Collective Bargaining Law), with the intention of being maintained for an indefinite period of time; however, the City reserves its rights, under said applicable law, to alter and/or terminate the Program and/or any Plan.

Brief summaries of the benefits of each of the available health plans appear on the pages that follow. They are presented so that it is easy to compare the benefits of the different plans.

This Summary Program Description is for informational purposes only. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

SECTION FOURTEEN

SUMMARY DESCRIPTION OF HEALTH PLANS

GHI-CBP/EMPIRE BLUE CROSS AND BLUE SHIELD

GHI's Comprehensive Benefits Plan (GHI-CBP) allows subscribers the freedom to choose any physician worldwide. GHI provides two forms of coverage combined in one plan. Subscribers receive paid-in-full benefits when they choose care from one of GHI's participating physicians and other health care providers. GHI maintains a network of over 15,000 participating physicians in the New York metropolitan area and has many additional participating physicians and other health care providers throughout New York State and nationwide. All of these physicians and providers have agreed to accept GHI's allowances as payment in full. Covered services are paid directly to the participating provider. Home calls and office visits are subject to an \$8 co-pay charge. Benefits provided by GHI participating providers are not subject to deductibles, coinsurance, or maximums.

When you are unable to use the services of a participating provider, GHI also covers the services of non-participating providers. Payment for these services is made directly to you under a Major Medical Schedule. Payment is subject to yearly deductibles (\$135 per person, maximum \$400 per family); a calendar year maximum (\$100,000 per person); and a lifetime maximum (\$1 million per person). Payment is made at 80% of the Major Medical Schedule. After \$2,000 in coinsurance charges, GHI reimburses you at 100% of the Major Medical Schedule. Coverage for professional private-duty nursing, equipment, appliances, oxygen and hospitalization coverage in excess of your Empire Blue Cross and Blue Shield coverage, is also available as a Major Medical benefit.

A subscriber who chooses non-participating physicians for in-hospital care may incur catastrophic expenses. GHI Catastrophic Coverage pays additional amounts under such circumstances. Effective July 1, 1989 once a subscriber has \$4,000 in covered out-of-pocket expenses based upon physicians' usual and customary fees, GHI pays 100% of the reasonable and customary charges. The services to which Catastrophic Coverage applies and also the services which contribute to the \$4,000 deductible are: surgery, anesthesia, maternity care, in-hospital medical care, radiation, chemotherapy, and expenses related to in-hospital X-ray and laboratory services.

Hospital benefits are provided by Empire Blue Cross and Blue Shield. Hospital benefits include, in addition to coverage up to 21 days in full and 180 discount days for basic room and board in a semi-private room, reimbursement for the cost of administering blood transfusions and the payment of blood processing fees; up to 30 days of regular hospital benefits for mental and nervous disorders; coverage for substance abuse admissions for detoxification purposes; hospice care; emergency care; surgery rendered in the out-patient department of a hospital; pre-surgical testing; out-patient substance abuse rehabilitation; dialysis for kidney failure; and home care.

MANAGED CARE

NYC HEALTHLINE: GHI-CBP enrollees must call NYC HEALTHLINE prior to a hospital admission or surgical procedure rendered in the out-patient department of a hospital, or having certain procedures performed in a doctor's office. Failure to call NYC HEALTHLINE may result in a penalty of up to \$500 from either your GHI or Empire Blue Cross and Blue Shield coverage. Subscribers and Medicare eligible retirees living outside the tri-state area are not required to call NYC HEALTHLINE. See page 10 for more detailed information on this important program.

Out-Patient Substance Abuse Treatment: To preserve your full health insurance benefits for out-patient alcoholism treatment, you must call your Employee Assistance Program (EAP), the City's Central EAP Referral Unit (212) 566-0103 or 0104, or your union counselling service for a referral letter; if you fail to do so, you will be subject to penalties.

Prior to the utilization of out-patient services for drug abuse, all subscribers, except for employees of the Police and Correction Departments and employees in the Probation Officer title series, should contact their agency EAPs for appropriate case review, referral and follow-up. Em-

ployees of the Police and Correction Departments and those in the Probation Officer title series cannot utilize their agencies' EAP or the Central EAP Referral Unit if they wish to use the out-patient drug benefit, but may instead self-refer to out-patient treatment facilities until further notice.

If you need help finding your EAP's phone number, call NYC HEALTHLINE or the Central EAP Referral Unit for assistance.

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

OPTIONAL BENEFITS RIDER

The GHI-CBP/Empire Blue Cross and Blue Shield program offers an optional rider for employees and for retirees who are not eligible for Medicare, with these additional benefits: Prescription drugs at 80% of reasonable and customary charges (subject to an annual \$150 deductible, \$450 per family); Maintenance drug plan (\$8 co-payment for a 60-day supply); 365-day Empire Blue Cross and Blue Shield hospitalization; \$250 maximum co-insurance (\$500 as of 1/1/90), reduced from \$2,000 under the Basic Plan (After the Major Medical deductible has been met, plan pays 80% of scheduled allowance; once a member's 20% co-insurance expenses reach \$250 (\$500 as of 1/1/90), plan pays 100% of scheduled allowance); Newborn well-baby care (out-of-hospital, maximum 5 visits before age one) to be included in basic plan effective 7/1/89; Full Blue Cross coverage for 5 additional days in-patient detoxification and up to 30 days rehabilitation per calendar year in an approved in-patient treatment facility for alcoholism (this will include treatment for drug abuse effective 7/1/89); Out-patient psychiatric care: 50% of submitted charge up to a maximum payment of \$30 per visit, \$700 annual maximum, \$2,500 lifetime maximum; Empire Blue Cross and Blue Shield coverage for unmarried full-time dependent students to age 23; increased Major Medical schedule for in-hospital and related procedures effective 1/1/90 (increase on average is 50% higher than current schedule).

GHI SENIOR CARE

If you are Medicare eligible and retired, GHI Senior Care supplements Medicare for home and office visits, surgery and anesthesia, dental surgery, maternity care, in-hospital medical care, radiation therapy, specialist consultations, diagnostic procedures, X-ray examination and laboratory tests, shock therapy and intermittent nurse service in your home (Visiting Nurse Service). Medicare pays 80% of the Medicare scheduled allowance and GHI Senior Care pays the remaining 20% both in and out of the hospital. If the Medicare deductible has been met through any of the above services, GHI Senior Care will reimburse you that deductible. You are covered for home and office visits. Empire Blue Cross and Blue Shield will fully supplement Medicare for hospital services. Empire Blue Cross and Blue Shield will pay the Medicare in-patient deductible. See pages 42 and 43 for more information.

Prescription and maintenance drug coverage, as described above for non-Medicare employees, is also available under an optional rider. You will receive additional information on how this optional rider will be provided and how it may be obtained.

COST

All plan costs are noted on page 44.

You may contact the health plans at:

Group Health Incorporated
330 West 42nd Street
New York, NY 10036
(212) 760-6808

Empire Blue Cross and Blue Shield
City of New York Dedicated Service Center
P.O. Box 4883 Grand Central Station
New York, NY 10163
Telephone: 212-972-3700 or 1-800-433-9592

GHI has a special Transfer Period phone number. Call (212) 760-6839.

GHI-CBP/EMPIRE BLUE CROSS AND BLUE SHIELD

	Cost to You When Using a Participating Provider \$8 Co-payment per visit	Cost to You When Using a Non-participating Provider *20% after deductible
OUT-PATIENT CARE		
PHYSICIANS' OFFICE VISITS	Covered in full when pre-certified by NYC HEALTHLINE	*20% after deductible when pre-certified by NYC HEALTHLINE
SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-PATIENT	Covered in full	*20% after deductible
LABORATORY AND X-RAY SERVICES		
HOSPITAL CARE		
SEMI-PRIVATE ROOM AND BOARD	Covers 21 Full-180 Discount Days (additional coverage through the optional rider)	Covers 21 Full-180 Discount Days (additional coverage through the optional rider)
PHYSICIANS' AND SURGEONS' SERVICES	Covered in full	*20% after deductible
GENERAL NURSING CARE	Covered in full	GHI Major Medical covers admissions for diagnostic studies, physical therapy, rehabilitation, and excess days not covered by Empire Blue Cross and Blue Shield.
DRUGS AND MEDICATION	Covered in full	Covered in full
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)	Covered in full	Covered in full
INTENSIVE AND CORONARY CARE UNITS	Covered in full	Covered in full
USE OF OPERATING AND RECOVERY ROOM	Covered in full	Covered in full
ANESTHESIA	Covered in full	*20% after deductible
EMERGENCY CARE		
AMBULANCE SERVICE	Covered up to \$75 (depending on mileage)	Covered up to \$75 (depending on mileage)
IN DOCTORS' OFFICES	Covered in full	*20% after deductible
HOSPITAL EMERGENCY ROOM	\$25 co-pay waived if admitted to hospital	\$25 co-pay waived if admitted to hospital
URGENT CARE FACILITY	Covered in full	*20% after deductible
PREVENTIVE CARE		
ROUTINE PHYSICAL CHECK-UP	Not Covered	Not Covered
ROUTINE PEDIATRIC (WELL-BABY) CARE	See optional rider, included in basic coverage July 1, 1989	See optional rider, included in basic coverage July 1, 1989
IMMUNIZATIONS	Not Covered	Not Covered
ROUTINE HEARING EXAMINATIONS	Not Covered	Not Covered
VISION CARE	Not Covered	Not Covered
MENTAL HEALTH CARE		
OUT-PATIENT		
DRUG ABUSE	Covered in full at a RECOVERReview SM treatment facility—60 visit combined annual maximum for drug and/or alcohol treatment	Balance after 80% payment of allowable charges in an approved facility—60 visit combined annual maximum for drug and/or alcohol treatment
ALCOHOL ABUSE	Covered in full at a RECOVERReview SM (formerly Alc-Net) treatment facility—60-visit combined annual maximum for drug and/or alcohol treatment	Balance after 80% payment of allowable charges in an approved facility—60 visit combined annual maximum for drug and/or alcohol treatment
IN-PATIENT		
MENTAL HEALTH	See optional rider	See optional rider
DRUG ABUSE	Detoxification—Covered in full up to 14 days per admission; 30 day combined annual maximum for drug, alcohol and/or mental health treatment	Detoxification—Covered in full up to 14 days per admission; 30 day combined annual maximum for drug, alcohol and/or mental health treatment
ALCOHOL ABUSE	Rehabilitation—See optional rider	Rehabilitation—See optional rider
MENTAL HEALTH	Detoxification—Covered in full up to 5 days per admission; 30 day combined annual maximum for drug, alcohol and/or mental health treatment (See optional rider for additional benefits)	Detoxification—Covered in full 5 days per admission; 30 day combined annual maximum for drug, alcohol and/or mental health treatment (See optional rider for additional benefits)
	Rehabilitation—See optional rider	Rehabilitation—See optional rider
	Physician: covered in full;	*Physicians—20% after deductible.
	Hospital: Covered in full 30 days per year in a non-governmental general hospital (additional Major Medical \$10,000 maximum per year, \$20,000 lifetime maximum). 30-day combined annual maximum for drug, alcohol and/or mental health treatment	Hospital: 30 days per year in a non-governmental general hospital (additional Major Medical: \$10,000 maximum per year; \$20,000 lifetime maximum). 30-day combined annual maximum for drug, alcohol and/or mental health treatment
MATERNITY CARE		
IN PHYSICIANS' OFFICES	Covered in full	*20% after deductible
PRE-NATAL AND POST-NATAL VISITS		
IN THE HOSPITAL		
PHYSICIANS' SERVICES—		
MOTHER AND NEWBORN	Mother—Covered in full	*Mother—20% after deductible
NEWBORN NURSERY SERVICES	Newborn—Covered only if medically necessary	Newborn—Covered only if medically necessary
MOTHER'S HOSPITAL SERVICES	Not Covered unless medically necessary	Not Covered unless medically necessary
	Covered in full by Empire Blue Cross and Blue Shield	Covered in full by Empire Blue Cross and Blue Shield
HOME HEALTH CARE		
HOME CARE SERVICES	Covered by Empire Blue Cross and Blue Shield	Covered by Empire Blue Cross and Blue Shield
HOSPICE CARE	Up to 210 days covered by Empire Blue Cross and Blue Shield	Up to 210 days covered by Empire Blue Cross and Blue Shield
SKILLED NURSING FACILITY	See Medicare coverage	See Medicare coverage
REHABILITATION		
PHYSICAL	Covered in full—eight visit maximum per year	*20% after deductible—eight visit maximum per year
SPEECH	Covered in full	*20% after deductible
PHARMACY SERVICES	See optional rider	See optional rider
FULL-TIME STUDENTS	GHI medical benefits—covered to age 23	GHI medical benefits—covered to age 23
	Hospitalization through optional rider to age 23	Hospitalization through optional rider to age 23

*When non-participating providers are used, Major Medical coverage applies; subject to a \$135 deductible per person per calendar year; \$400 maximum family deductible, allowance based on 80% of Major Medical schedule. After patient's out-of-pocket expense reaches \$2,000, plan pays 100% of allowance on schedule; \$100,000 annual maximum, \$1 million lifetime maximum.

GHI TYPE C/EMPIRE BLUE CROSS AND BLUE SHIELD

GHI's Type C Program is a plan that is usually recommended for Medicare eligible retirees. For employees and non-Medicare eligible retirees, payment for physicians' bills is based on a schedule of allowances that has not been significantly improved since 1974. There is no deductible or coinsurance required. Benefits are available worldwide. Payments are made for diagnosis, general medical care, immunization visits, treatment of illnesses, allergy desensitization, and well-baby care.

GHI Pays

Home Visit	\$10
Office Visit	\$ 7

Included in the benefit package are surgery and anesthesia, dental surgery, maternity care, in-hospital medical care, radiation therapy, specialist consultations, diagnostic procedures, X-ray examinations, lab tests, shock therapy, and intermittent nurse service in your home. Also covered are: ambulance services, private-duty professional nursing services, appliances, equipment, and oxygen (all of which have a \$25 annual deductible and coinsurance).

Hospital benefits are provided by Empire Blue Cross and Blue Shield. Hospital benefits include: basic room and board in a semi-private room, reimbursement for the cost of administering blood transfusions and the payment of blood processing fees, up to 30 days of regular hospital benefits for mental and nervous disorders, coverage for substance abuse admissions for detoxification purposes, hospice care, emergency care, surgery rendered in the out-patient department of a hospital, pre-surgical testing, out-patient substance abuse rehabilitation, dialysis for kidney failure and home care.

MANAGED CARE

NYC HEALTHLINE: GHI Type C enrollees must call NYC HEALTHLINE prior to a hospital admission or surgical procedure in the out-patient department of a hospital, or certain procedures in a doctor's office. Failure to call NYC HEALTHLINE may result in a penalty of up to \$500 from either your GHI or Empire Blue Cross and Blue Shield coverage. Subscribers and Medicare eligible retirees living outside the tri-state area are not required to call NYC HEALTHLINE. See page 10 for more detailed information on this important program.

Out-Patient Substance Abuse Treatment: To preserve your full health insurance benefits for out-patient alcoholism treatment, you must call your Employee Assistance Program (EAP), the City's Central EAP Referral Unit (212) 566-0103 or 0104, or your union counselling service for a referral letter; if you fail to do so, you will be subject to penalties.

Prior to the utilization of out-patient services for drug abuse, all subscribers, except for employees of the Police and Correction Departments and employees in the Probation Officer title series, should contact their agency EAPs for appropriate case review, referral and follow-up. Employees of the Police and Correction Departments and those in the Probation Officer title series cannot utilize their agencies' EAP or the Central EAP Referral Unit if they wish to use the out-patient drug benefit, but may instead self-refer to out-patient treatment facilities until further notice.

If you need help finding your EAP's phone number, call NYC HEALTHLINE or the Central EAP Referral Unit for assistance.

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

OPTIONAL BENEFITS RIDER

The program offers an optional rider with these additional benefits: prescription drugs at 80% of reasonable and customary charges (subject to an annual \$150 deductible per person and \$450 per family); maintenance drug plan (\$8 for a 60-day supply); and 365-day Empire Blue Cross and Blue Shield hospitalization. If your welfare fund provides benefits similar to those listed in the rider, those specific benefits will be provided through your welfare fund and the payroll or pension deduction will be reduced accordingly.

GHI SENIOR CARE

If you are Medicare eligible and retired, GHI Senior Care supplements Medicare for home and office visits, surgery and anesthesia, dental surgery, maternity care, in-hospital medical care, radiation therapy, specialist consultations, diagnostic procedures, X-ray examination and laboratory tests, shock therapy and intermittent nurse service in your home (Visiting Nurse Service). Medicare pays 80% of the Medicare scheduled allowance and GHI Senior Care pays the remaining 20% both in and out of the hospital. If the Medicare deductible has been met through any of the above services, GHI Senior Care will reimburse you that deductible. You are covered for home and office visits. Empire Blue Cross and Blue Shield will fully supplement Medicare for hospital services. Empire Blue Cross and Blue Shield will pay the Medicare in-patient deductible. See pages 42 and 43 for more information. A prescription and maintenance drug rider, described above for non-Medicare employees, is also available.

COST

All plan costs are noted on page 44.

You may contact the health plans at:

Group Health Incorporated
330 West 42nd Street
New York, NY 10036
(212) 760-6808

Empire Blue Cross and Blue Shield
City of New York Dedicated Service Center
P.O. Box 4883 Grand Central Station
New York, NY 10163
Telephone: 212-972-3700 or 1-800-433-9592

GHI TYPE C/EMPIRE BLUE CROSS AND BLUE SHIELD

OUT-PATIENT CARE

PHYSICIANS' OFFICE VISITS
SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-
PATIENT
LABORATORY AND X-RAY SERVICES

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
PHYSICIANS' AND SURGEONS' SERVICES
GENERAL NURSING CARE
DRUGS AND MEDICATION
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
INTENSIVE AND CORONARY CARE UNITS
USE OF OPERATING AND RECOVERY ROOM
ANESTHESIA

EMERGENCY CARE

AMBULANCE SERVICE
IN DOCTORS' OFFICES
HOSPITAL EMERGENCY ROOM

URGENT CARE FACILITY

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
ROUTINE PEDIATRIC (WELL-BABY) CARE
IMMUNIZATIONS
ROUTINE HEARING EXAMINATIONS
VISION CARE

MENTAL HEALTH CARE

OUT-PATIENT DRUG ABUSE

ALCOHOL ABUSE

IN-PATIENT MENTAL HEALTH
 DRUG ABUSE

ALCOHOL ABUSE

MENTAL HEALTH

MATERNITY CARE

IN PHYSICIANS' OFFICES
PRE-NATAL AND POST-NATAL VISITS
IN THE HOSPITAL
PHYSICIANS' SERVICES—MOTHER AND NEWBORN

NEWBORN NURSERY SERVICES
MOTHER'S HOSPITAL SERVICES

HOME HEALTH CARE

HOME CARE SERVICES

HOSPICE CARE

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL
SPEECH

PHARMACY SERVICES

FULL-TIME STUDENTS

Benefits

\$7 per visit

Per Schedule of Allowances
Per Schedule of Allowances

21 Full—180 Discount Days
Per Schedule of Allowances
Payment in full
Payment in full
Payment in full
Payment in full
Per Schedule of Allowances

Submitted Charge or \$25, whichever is less
\$7 per visit
Covered within 12 hours of illness or 72 hours of
accident
\$7 per visit

\$7 per visit
\$7 per visit
\$7 per visit
Not Covered
Not Covered

Covered in full at a RECOVERReviewSM treatment facility;
80% of allowable charges in an approved facility—60-
visit combined annual maximum for drug and/or
alcohol treatment
Covered in full at a RECOVERReviewSM treatment facility
(formerly Alc-Net); covered 80% of allowable charge in
an approved facility—60 day combined annual
maximum for drug and/or alcohol treatment
Not Covered
Detoxification—up to 14 days per admission; 30 day
combined annual maximum for drug, alcohol and/or
mental health treatment
Rehabilitation—Not Covered
Detoxification—up to 5 days per admission; 30 day
combined annual maximum for drug, alcohol and/or
mental health treatment
Rehabilitation—Not Covered
Physician or psychologist: covered per schedule of
allowances
Hospital: 30 days per year in a non-governmental general
hospital. 30 day combined annual maximum for drug,
alcohol and/or mental health treatment

Per Schedule of Allowances

Mother—Per Schedule of Allowances
Newborn—Per Schedule of Allowances
Not Covered unless medically necessary
Covered in full by Empire Blue Cross and Blue Shield

Covered up to 200 visits by Empire Blue Cross and Blue
Shield
Covered up to 210 days by Empire Blue Cross and Blue
Shield
Not Covered

\$7 per visit, 4 visits per year
\$7 per visit, 16 visits per year
See Optional Rider
GHI medical benefits to age 23; hospital benefits to age 19

EMPIRE BLUE CROSS AND BLUE SHIELD— HEALTHNET

HEALTHNET is a program offered by Empire Blue Cross and Blue Shield. HEALTHNET is an Individual Practice Association (IPA) form of a Health Maintenance Organization (HMO) which allows members to choose their primary care physicians from a Provider Directory of nearly 2,000 participating primary care physicians and over 5,000 specialists who are located throughout the 27-county HEALTHNET service area of New York State.

Comprehensive health care benefits when provided or authorized by a HEALTHNET primary care physician include not only full coverage for unlimited days of hospital care, but full coverage for referral to specialists, preventive care (including physical examinations, well-child care, Pap tests, comprehensive eye examinations, family planning, and health and nutrition counseling), maternity care, durable medical equipment, home health care, and skilled nursing care facilities.

Each member of HEALTHNET, as well as each family member, chooses a primary care physician to provide and manage their health care needs. The primary care physician is responsible for referrals to specialists and arranging hospitalization and any other needed medical and health care services.

Medical services are rendered in either a physician's private office or at a physician's office at a group practice center, as well as their affiliated hospital when necessary. There is a \$5 co-payment required for each office visit to a primary care physician. Referral to specialists, well-child care, and pre-natal care are covered in full, without charge. All services authorized by the primary care physician are covered.

Customary hospitalization charges, as well as newborn nursery charges are covered in full. Emergency room services require a \$35 co-payment, unless followed by hospitalization for the same condition within three days.

Emergency room care when traveling in or outside the HEALTHNET service area is covered when the onset of the medical condition was unexpected and of such a nature that failure to obtain immediate care would result in a deterioration of the patient's condition which would cause serious impairment or threat to life. Your HEALTHNET primary care physician must be notified within three days if you are hospitalized.

Urgent care is non-emergency care, but still a condition which requires immediate attention, and cannot wait until your return to your primary care physician and the HEALTHNET service area. When out-of-area urgent care is needed, members should call their primary care physician for medical direction. Whatever is authorized will be covered in full (excluding prescriptions). You may also call HEALTHNET toll-free at 1-800-342-9741 for information on the availability of medical care in the area in which you are traveling.

HEALTHNET MEDICARE

If you are Medicare eligible and retired with both Medicare Parts A and B you are also eligible for HEALTHNET. This plan provides the same comprehensive benefits of the standard HEALTHNET program which includes coverage for the deductibles, coinsurance, and services not covered by Medicare Parts A and B, but not to exceed the standard coverage provided through HEALTHNET's program. To be covered in full, Medicare eligibles must use HEALTHNET physicians. If a non-HEALTHNET physician is used, only Medicare coverage is applicable and care is subject to deductibles, co-payments, and exclusions. See pages 42 and 43 for additional information on the HEALTHNET Medicare Program.

COST

An optional rider for prescription drugs (\$5 co-pay per prescription or refill) is also available to subscribers through Empire Blue Cross and Blue Shield HEALTHNET.

Please see page 45 for more information on payroll or pension deductions.

You may contact the health plan at 622 Third Ave., New York, N.Y., (212) 869-2620.

EMPIRE BLUE CROSS AND BLUE SHIELD— HEALTHNET

OUT-PATIENT CARE

PHYSICIANS' OFFICE VISITS
SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-
PATIENT
LABORATORY AND X-RAY SERVICES

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
PHYSICIANS' AND SURGEONS' SERVICES
GENERAL NURSING CARE
DRUGS AND MEDICATION
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
INTENSIVE AND CORONARY CARE UNITS
USE OF OPERATING AND RECOVERY ROOM
ANESTHESIA

EMERGENCY CARE

AMBULANCE SERVICE
IN DOCTORS' OFFICES
HOSPITAL EMERGENCY ROOM

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
ROUTINE PEDIATRIC (WELL-BABY) CARE
IMMUNIZATIONS
ROUTINE HEARING EXAMINATIONS
VISION CARE

MENTAL HEALTH CARE

OUT-PATIENT DRUG ABUSE

ALCOHOL ABUSE

IN-PATIENT

MENTAL HEALTH
DRUG ABUSE

ALCOHOL ABUSE

MENTAL HEALTH

MATERNITY CARE

IN PHYSICIANS' OFFICES
PRE-NATAL AND POST-NATAL VISITS
IN THE HOSPITAL
PHYSICIANS' SERVICES—MOTHER AND NEWBORN
NEWBORN NURSERY SERVICES
MOTHER'S HOSPITAL SERVICES

HOME HEALTH CARE

HOME CARE SERVICES
HOSPICE CARE

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL
SPEECH

PHARMACY SERVICES

FULL-TIME STUDENTS

Cost To You

*\$5 Co-payment (Primary Care Only)

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*\$5 Co-payment (Primary Care Only)

*\$35 Co-payment: waived if hospitalized within 72 hours

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

**Covered in full—in an approved treatment facility—60
visit combined annual maximum for drug and/or
alcohol treatment

**Covered in full—in an approved treatment facility—60
visit combined annual maximum for drug and/or
alcohol treatment

*\$25 Co-payment up to 20 visits per calendar year

**Detoxification—Covered in full up to 14 days (per
incident) in hospital; 30 days maximum per year

*Rehabilitation—Covered in full up to 30 days, 90 days
day/night care (non-medical facility). 120 day
combined annual maximum for drug and/or alcohol
treatment

**Detoxification—Covered in full up to 7 days (per
incident) in hospital; 30 days maximum per year

*Rehabilitation—Covered in full up to 30 days, 90 days
day/night care (non-medical facility). 120 day
combined annual maximum for drug and/or alcohol
treatment

*Covered in full up to 30 days

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full when medically appropriate—30 days

*Covered in full—short term rehabilitation—20 visits

*Covered in full

See Optional Rider

Covered to age 25

* All services must be provided or authorized by your HEALTHNET Primary Care Physician.

** When authorized or provided by a HEALTHNET physician or referred by the Employee Assistance Program (EAP).

HIP/HMO

The Health Insurance Plan of Greater New York (HIP) was the first health plan of its kind in New York and is the largest Health Maintenance Organization (HMO) outside of California. HIP/HMO provides comprehensive hospitalization and medical benefits to over 900,000 New Yorkers, including over 350,000 City employees, retirees and their family members.

Medical care is provided by the more than 1,000 selected doctors of HIP at over 50 multi-specialty and primary care centers located in the five boroughs of New York City, Nassau, Suffolk and Westchester counties and New Jersey.

Members of HIP/HMO, by using HIP services, have no doctor bills, no hospital bills and no claim forms. There are no limitations on medical visits and hospitalization is covered in full.

Members, upon joining, select a medical group, a medical center and a personal family physician for adults and a pediatrician for dependent children. These physicians have the responsibility for primary care and for referrals to other specialists affiliated with the medical group. A full range of one-stop medical services is then available, generally at the member's center, occasionally through referral elsewhere.

Visits to the medical center are by appointment. If an urgent medical need arises, members can call the center for a same day appointment. If an emergency arises when the centers are closed (evenings, weekends or holidays), the Emergency Services Program (ESP) should be called toll free at 1-800-HIP-HELP. Through ESP, HIP provides around-the-clock access to urgent and emergency medical care; both physicians and nurses are available to give advice or referrals to an HIP-after-hour Treatment Center, or hospital emergency room. Emergency hospitalization and medical care are covered when a member is traveling, or so severely injured that authorization by HIP is not feasible.

OPTIONAL BENEFITS RIDER

HIP/HMO offers an optional rider which provides full coverage for prescription drugs at over 2,000 participating pharmacies. The rider also covers appliances provided through designated suppliers and private duty nursing (in-hospital only) when prescribed by an HIP physician. If your welfare fund provides benefits similar to those listed in the rider, those specific benefits will be provided through your welfare fund and your payroll or pension deductions will be reduced accordingly.

HIP "FITNESS FORMULA" BENEFITS

As part of HIP's ongoing commitment to keeping members healthy, several programs are offered including Smoking Cessation Program, Weight Management Program and Fitness Incentives. Please refer to your HIP booklet for more information on these programs.

HIP VIP MEDICARE PROGRAM

The HIP VIP Medicare Program provides comprehensive medical and hospital benefits to City of New York retirees and their spouses who are enrolled in Parts A and B of Medicare. Medicare eligible retirees **must** be enrolled in Medicare Part B. However, Medicare eligible retirees who are not eligible for Part A may remain in HIP. There are no pension deductions or additional charges for the HIP VIP Plan which includes these additional benefits:

Full coverage for prescription drugs prescribed by your HIP physician and obtained through any one of more than 2,000 participating pharmacies; prescription eyeglasses every 24 months (from a special selection); in-hospital private duty nursing when ordered by an HIP physician; full coverage for short term treatment of mental or nervous disorders; and certain prosthetic devices and appliances.

In exchange for the comprehensive medical and full hospital coverage plus all the special benefits available through HIP VIP, the Member agrees to obtain all his or her medical and hospital services through HIP. Any medical care, except for covered emergencies or urgently

needed care out of the area, that is neither provided nor authorized by HIP, will not be covered by either HIP or Medicare.

FLORIDA RESIDENTS: Current enrollees and those newly electing HIP coverage will be provided with medical care through the HIP/HMO Medicare Supplemental Program (MSP). Under this program enrollees may continue to use the services of HIP and will retain the use of their Medicare card outside HIP. See the next section for more information.

HIP/HMO MEDICARE SUPPLEMENTAL PROGRAM

HIP/HMO MSP will continue to provide comprehensive medical and hospital benefits to New York City retirees and their spouses enrolled in Parts A and B of Medicare who were members of HIP/HMO MSP prior to July 1, 1987.

The benefits available to the Medicare Supplemental members are the same as those described for HIP/HMO, with the following additional benefits at no cost:

In-hospital private duty nursing when ordered by an HIP physician, psychiatric services for mental or nervous disorders, and certain prosthetic devices and appliances.

Elective medical services (non-emergency) provided by non-HIP physicians are covered only by Medicare and are subject to Medicare deductibles, coinsurance payments and exclusions. HIP does not supplement Medicare coverage for such services. HIP Supplementary Medicare members may also choose full coverage of prescription drugs through an optional rider. The election of this benefit results in monthly pension deductions. For more information on the HIP Supplementary Medicare program see pages 42 and 43.

HIP IN FLORIDA

HIP is able to serve its members who live or travel in South Florida, through its affiliate, HIP Network of Florida. Services are provided in Dade, Broward and Palm Beach counties. Benefits and rates are the same as in New York. Members vacationing in the Florida service area may arrange reciprocity through Interplan, either in advance or upon determining that care is needed.

Those employees and retirees who are planning a vacation in the Florida service area, may arrange for medical treatment by calling HIP Interplan at **1-800-223-0654**. They will be referred to an HIP physician whose office is near the location where they will be staying. Employees who are retiring and moving to the HIP Network service area may arrange to receive services from the HIP Network by contacting the HIP Member Services Department (1-800-HIP-TALK).

COST

All plan costs are noted on page 44.

You may contact the health plan at 220 West 58th Street, New York, N.Y. 10019, 1-800-HIP-TALK.

During the New York City transfer period, specially trained representatives will be available during the following periods: Monday to Thursday, 5:00 PM to 7:30 PM.

HIP/HMO

OUT-PATIENT CARE

PHYSICIANS' OFFICE VISITS
 SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-
 PATIENT
 LABORATORY AND X-RAY SERVICES

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
 PHYSICIANS' AND SURGEONS' SERVICES
 GENERAL NURSING CARE
 DRUGS AND MEDICATION
 DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
 INTENSIVE AND CORONARY CARE UNITS
 USE OF OPERATING AND RECOVERY ROOM
 ANESTHESIA

EMERGENCY CARE

AMBULANCE SERVICE

IN DOCTORS' OFFICES

HOSPITAL EMERGENCY ROOM
 URGENT CARE FACILITY

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
 ROUTINE PEDIATRIC (WELL-BABY) CARE
 IMMUNIZATIONS
 ROUTINE HEARING EXAMINATIONS
 VISION CARE

MENTAL HEALTH CARE

OUT-PATIENT	DRUG ABUSE
	ALCOHOL ABUSE
IN-PATIENT	MENTAL HEALTH DRUG ABUSE
	ALCOHOL ABUSE
	MENTAL HEALTH

MATERNITY CARE

IN PHYSICIANS' OFFICES
 PRE-NATAL AND POST-NATAL VISITS
 IN THE HOSPITAL
 PHYSICIANS' SERVICES—MOTHER AND NEWBORN
 NEWBORN NURSERY SERVICES
 MOTHER'S HOSPITAL SERVICES

HOME HEALTH CARE

HOME CARE SERVICES
 HOSPICE CARE

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL
 SPEECH

PHARMACY SERVICES

FULL-TIME STUDENTS

Cost To You

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

Covered in full when authorized by HIP, otherwise
 100% of usual and customary charge

Covered in full when authorized by HIP, otherwise
 100% of usual and customary charge

Covered in full

Covered in full when authorized by HIP, otherwise
 100% of usual and customary charge

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

***Covered in full—60-visit combined annual maximum
 for drug and/or alcohol treatment

***Covered in full—60-visit combined annual maximum
 for drug and/or alcohol treatment

*One psychiatric assessment visit per year at HIP

*Detoxification—Covered in full: 30-day combined
 annual maximum for drug, alcohol, and/or mental
 health treatment

Rehabilitation—Not Covered

*Detoxification—Covered in full: 30-day combined
 annual maximum for drug, alcohol, and/or mental
 health treatment

Rehabilitation—Not Covered

*Covered in full—30 days per year in a psychiatric
 section of a general hospital: 30-day combined annual
 maximum for drug, alcohol, and/or mental health
 treatment

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in lieu of in-patient stay

*Covered up to 210 days

**Covered in full when criteria are met

*Covered in full for first 30 days of each admission

*Covered in full for first 30 days of each admission
 Available through optional rider

Covered to age 23

* When provided or authorized by an HIP Physician.

** Authorized when care (1) follows a stay in the hospital, and (2) is in lieu of hospitalization.

*** When authorized or provided by an HIP Physician or referred by the Employee Assistance Program (EAP).

HIP CHOICE

HIP CHOICE allows the flexibility of receiving care from the physicians of HIP while maintaining the option to use any other physician whenever desired. Under this plan, all benefits to HIP/HMO members are available when provided or arranged by HIP doctors, including full coverage for check-ups, well-baby care, routine immunizations, and eye exams. There are no deductibles, co-payments, or penalties for services provided by HIP. Hospitalization by an HIP doctor is also fully covered.

In addition, the HIP CHOICE subscriber can use any other doctors at any time and be reimbursed for up to 60% of the doctor's fee. Coverage is subject to a deductible. Full coverage for in-patient hospital care, skilled nursing facility care and home care, arranged by non-HIP physicians is available if prior approval is obtained from HIP through TEAM CARE. If you choose HIP CHOICE, you will receive additional information and the phone number for TEAM CARE.

For care from non-HIP doctors, HIP CHOICE members are subject to a \$200 deductible per individual, per year, with a \$400 annual family maximum. Thereafter, members will be reimbursed for 60% of what HIP CHOICE determines as reasonable and customary charges for the services provided. Co-insurance is the responsibility of the subscriber but only until a \$1,000 annual maximum per individual or \$2,000 per family is reached. HIP CHOICE will then pay 100% of further reasonable and customary charges. The member will still be responsible for any charges above what HIP considers reasonable and customary. Periodic health exams, well-baby care, routine immunizations, and eye exams are not covered when provided by a non-HIP doctor.

OPTIONAL BENEFITS RIDER

HIP CHOICE offers an optional rider. The rider fully covers, at over 2,000 participating pharmacies, drugs prescribed by an HIP physician. Prescription drugs not prescribed by an HIP physician are subject to a \$3 co-payment at participating pharmacies, per 30 day supply.

HIP "STAY HEALTHY" BENEFITS

As part of HIP's ongoing commitment to keeping members healthy, several programs are offered including Smoking Cessation Program, Weight Management Program, and Fitness Incentives.

Please refer to your HIP booklet for more information on these programs.

HIP VIP MEDICARE PROGRAM

The HIP VIP Medicare Program provides comprehensive medical and hospital benefits to City of New York retirees and their spouses who are enrolled in Parts A and B of Medicare. Medicare eligible retirees **must** be enrolled in Medicare Part B. However, Medicare eligible retirees who are not eligible for Part A may remain in HIP. There are no pension deductions or additional charges for the HIP VIP Plan which includes these additional benefits:

Full coverage for prescription drugs prescribed by your HIP physician and obtained through any one of more than 2,000 participating pharmacies; prescription eyeglasses every 24 months (from a special selection); in-hospital private duty nursing when ordered by an HIP physician; full coverage for short term treatment of mental or nervous disorders, and certain prosthetic devices and appliances.

In exchange for the comprehensive medical and full hospital coverage plus all the special benefits available through HIP VIP, the Member agrees to obtain all his or her medical and hospital services through HIP. Any medical care, except for covered emergencies or urgently needed care out of the area that is neither provided nor authorized by HIP will not be covered by either HIP or Medicare.

FLORIDA RESIDENTS: Current enrollees and those newly electing HIP coverage will be provided with medical care through the HIP/HMO Medicare Supplemental Program (MSP). Under this program enrollees may continue to use the services of HIP and will retain the use of their Medicare card outside HIP. See the next section for more information.

HIP/HMO MEDICARE SUPPLEMENTAL PROGRAM

HIP/HMO MSP will continue to provide comprehensive medical and hospital benefits to New York City retirees and their spouses enrolled in Parts A and B of Medicare who were members of HIP/HMO MSP prior to July 1, 1987.

The benefits available to the Medicare Supplemental members are the same as those described for HIP/HMO, with the following additional benefits at no cost:

In-hospital private duty nursing when ordered by an HIP physician, psychiatric services for mental or nervous disorders, and certain prosthetic devices and appliances.

Elective medical services (non-emergency) provided by non-HIP physicians are covered only by Medicare and are subject to Medicare deductibles, coinsurance payments, and exclusions. HIP does not supplement coverage for such services. HIP Supplementary Medicare members may also choose full coverage of prescription drugs through an optional rider. The election of this benefit results in monthly pension deductions. For more information on the HIP Medicare Supplemental Program, turn to pages 42 and 43.

HIP IN FLORIDA

HIP is able to serve its members who live or travel in South Florida, through its affiliate, HIP Network of Florida. Services are provided in Dade, Broward and Palm Beach counties. Benefits and rates are the same as in New York. Members vacationing in the Florida service area may arrange reciprocity through Interplan, either in advance or upon determining that care is needed.

Those employees and retirees who are planning a vacation in the Florida service area, may arrange for medical treatment by calling HIP Interplan at **1-800-223-0654**. They will be referred to an HIP physician whose office is near the location where they will be staying. Employees who are retiring and moving to the HIP Network service area may arrange to receive services from the HIP Network by contacting the HIP Member Services Department (1-800-HIP-TALK).

HIP CHOICE coverage is not available to permanent residents of Florida. HIP CHOICE members may arrange to receive treatment from HIP affiliated physicians through HIP Interplan or may receive treatment from any physician, subject to the deductible and co-payment.

COST

All plan costs are noted on page 45.

For additional information, call 1-800-HIP-TALK.

You may contact the health plan at 220 West 58th Street, New York, N.Y. 10019, 1-800-HIP-TALK.

During the New York City transfer period, specially trained representatives will be available during the following periods: Monday to Thursday, 5:00 PM to 7:30 PM.

HIP CHOICE

	SERVICES FROM HIP	COST TO YOU	SERVICES NOT FROM HIP
OUT-PATIENT CARE			
PHYSICIANS' OFFICE VISITS	Covered in full		*40%
SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-PATIENT	Covered in full		*40%
LABORATORY AND X-RAY SERVICES	Covered in full		*40%
HOSPITAL CARE			
SEMI-PRIVATE ROOM AND BOARD	Covered in full		**Covered in full
PHYSICIANS' AND SURGEONS' SERVICES	Covered in full		*40%
GENERAL NURSING CARE	Covered in full		**Covered in full
DRUGS AND MEDICATION	Covered in full		**Covered in full
DIAGNOSTIC SERVICES (LABWORK, X-RAYS)	Covered in full		**Covered in full
INTENSIVE AND CORONARY CARE UNITS	Covered in full		**Covered in full
USE OF OPERATING AND RECOVERY ROOMS	Covered in full		**Covered in full
ANESTHESIA	Covered in full		*40%
PRIVATE DUTY NURSING	Covered in full		**50%
EMERGENCY CARE			
AMBULANCE SERVICE	Covered in full in connection with hospital admission or covered Emergency Room services		Covered in full in connection with hospital admission or covered Emergency Room services
IN DOCTORS' OFFICES	Covered in full		*40%
HOSPITAL EMERGENCY ROOM	Covered in full within 12 hours of illness or 72 hours of accident		Covered in full within 12 hours of illness or 72 hours of accident
URGENT CARE FACILITY	Covered in full		*40% of physician services
PREVENTIVE CARE			
ROUTINE PHYSICAL CHECK-UP	Covered in full		Not covered
ROUTINE PEDIATRIC (WELL-BABY) CARE	Covered in full		Not covered
IMMUNIZATIONS	Covered in full		Not covered
ROUTINE HEARING EXAMINATIONS	Covered in full		Not covered
VISION CARE	Covered in full		Not covered
MENTAL HEALTH CARE			
OUT-PATIENT			
DRUG ABUSE	**Covered in full—60-visit combined annual maximum for drug and/or alcoholism treatment	†40%	
ALCOHOL ABUSE	**Covered in full—60-visit combined annual maximum for drug and/or alcoholism treatment	†40%	
IN-PATIENT			
MENTAL HEALTH	One psychiatric assessment visit per year at HIP		Not covered
DRUG ABUSE	**Detoxification—Covered in full Rehabilitation—Not covered		**Detoxification—Covered in full Rehabilitation—Not covered
ALCOHOL ABUSE	**Detoxification—Covered in full Rehabilitation—Not covered		**Detoxification—Covered in full Rehabilitation—Not covered
MENTAL HEALTH	**Covered in full for up to a maximum of 30 days per year		**Covered in full for up to a maximum of 30 days per year
MATERNITY CARE			
IN PHYSICIANS' OFFICES			
PRE-NATAL AND POST-NATAL VISITS	Covered in full		*40%
IN THE HOSPITAL			
PHYSICIANS' SERVICES—			
MOTHER AND NEWBORN	Covered in full		*40%—(Well-baby care not covered)
NEWBORN NURSERY SERVICES	Covered in full		Covered in full
MOTHER'S HOSPITAL SERVICES	Covered in full		Covered in full
HOME HEALTH CARE			
HOME CARE SERVICES	Covered in full		40 visits covered in full. Additional visits, 50% covered
HOSPICE CARE	210 days covered in full		210 days covered in full
SKILLED NURSING FACILITY	Covered in full following hospital stay and in lieu of hospitalization		Covered in full with approval; 50% without approval
REHABILITATION			
PHYSICAL	Covered in full—Limited to first 30 days of each admission		*40%—Limited to first 30 days of each admission
SPEECH	Covered in full—Limited to first 30 days of each admission		*40%—Limited to first 30 days of each admission
APPLIANCES	Covered in full		Covered in full with approval; 50% without approval
PHARMACY SERVICES	See optional rider		See optional rider
FULL-TIME STUDENTS	Covered to age 23		Covered to age 23

- *The subscriber must satisfy a deductible (\$200 per individual, \$400 per family) after which reimbursement will be 60% of the usual, customary, and reasonable charge. Subscriber must pay excess above usual, customary, and reasonable charge. When 40% coinsurance reaches \$1,000 per individual or \$2,000 per family in a calendar year, HIP CHOICE will pay 100% of the usual and customary charges for the remainder of the calendar year.
- **With prior approval of HIP, all Hospital, Skilled Nursing Facility, and Home Care services are covered in full, except that in-patient drug and/or alcohol detoxification and mental health services are limited to a total of 30 days per year.
- †Without prior approval or approval within first 10 days—coverage limited to 10 days. After deductible, HIP will pay 60% of reasonable and customary charges.

SANUS/NEW YORK LIFE

SANUS/NEW YORK LIFE, a subsidiary of the New York Life Insurance Company, offers to City of New York employees and retirees a high quality, comprehensive, health care plan. As one of the largest managed health care companies in the nation, SANUS/NEW YORK LIFE provides services to over 600,000 individuals nationwide through a network of over 15,000 private physicians. In addition, on November 1, 1988 SANUS/NEW YORK LIFE acquired the assets of Maxicare New York/New Jersey. All City employees covered by Maxicare are now automatically covered by SANUS/NEW YORK LIFE.

SANUS/NEW YORK LIFE has over 2,000 physicians and 75 prestigious hospitals participating in the greater New York metropolitan area. The hospital network includes, but is not limited to, Beth Israel, Columbia Presbyterian, Mount Sinai, New York Hospital, Montefiore, Brookdale, Long Island College, Maimonides, Staten Island, Long Island Jewish, Catholic Medical Centers, and Flushing Hospital. All participating physicians are board certified or board eligible and practice in their own private office. Please see the SANUS/NEW YORK LIFE Directory of Private Doctors for additional hospitals and doctors.

SANUS/NEW YORK LIFE is licensed to provide services in the following areas: in New York State, New York City, Nassau, Suffolk, Westchester, Orange, Putnam and Rockland counties. In New Jersey: Bergen, Essex, Hudson, Morris, Middlesex, Passaic, and Union counties. And for the first time the Washington D.C. plan, HealthPlus, is available to City of New York employees.

Each SANUS/NEW YORK LIFE member will choose a personal doctor who is either an internist, family practitioner, or a pediatrician. Additionally, each female member 18 years of age or older may choose a Sanus gynecologist of her choice, on an annual basis, for a complete Well-Woman Examination.

You may schedule an appointment to see your physician whom you have personally selected whenever you need medical care. Your primary care provider is responsible for arranging all your health care services including specialist visits and elective hospital admissions. You know in advance that SANUS/NEW YORK LIFE not only covers your health care needs but also stresses preventive care.

When you see your primary care doctor you pay only \$5.00. This includes all labs, x-rays and tests. Well baby care is covered in full and includes routine visits and all immunizations. SANUS/NEW YORK LIFE pays 100% for all specialty care, hospitalization, surgery, and anesthesia when authorized by your primary care doctor. Emergency care is covered anywhere in the world.

In case of a medical emergency, if you are unable to use a plan hospital, SANUS/NEW YORK LIFE will arrange to directly pay the non-plan hospital or physician, or reimburse the member. Members must notify SANUS/NEW YORK LIFE within 24 hours of the onset of the emergency for authorization. There is a \$40 co-payment for each emergency room visit which is waived if you are admitted to the hospital.

SANUS/NEW YORK LIFE HEALTHY DISCOUNT PROGRAM

As a member of SANUS/NEW YORK LIFE, you can enjoy the unique HEALTHY DISCOUNT PROGRAM which is part of the basic package. This includes: DENTAL DISCOUNTS, DISCOUNT FITNESS AND WEIGHT REDUCTION PROGRAMS, ANNUAL VISION EXAMINATIONS, ANNUAL PHYSICAL EXAMS, WOMEN'S WELLNESS PROGRAM, and DISCOUNT CONTACT LENS REPLACEMENTS.

For more details on these special benefits please refer to your SANUS/NEW YORK LIFE booklet which will be mailed to your home during the transfer period or you may call (718) 899-3600 or 1-800-338-8113 and ask for the City of New York hotline desk.

SANUS/NEW YORK LIFE MEDICARE

If you are Medicare eligible and retired with both Medicare parts A and B you are also eligible for SANUS/NEW YORK LIFE Medicare program. This plan includes coverage for the deductibles, coinsurance, and services not covered by Medicare parts A and B, but will not exceed the coverage provided through the standard SANUS/NEW YORK LIFE plan. To be covered in full, Medicare eligible members must use Sanus physicians. If a non-Sanus physician is used, only Medicare coverage is applicable and care is subject to deductibles, coinsurance, and exclusions. See pages 42 and 43 for additional information on the SANUS/NEW YORK LIFE Medicare program.

COST

An optional rider for prescription drugs is also available to SANUS/NEW YORK LIFE members. Mail service (maintenance) drugs are filled at no charge. There is a \$50 deductible for non-mail service (non-maintenance) drugs per individual, per year. After the deductible is satisfied, there is a \$3 charge per prescription or refill. SANUS/NEW YORK LIFE has over 300 participating pharmacies which you may use including but not limited to Pathmark.

Please see page 45 for more information on payroll deductions.

You may contact the health plan at 75-20 Astoria Boulevard, Jackson Heights, New York 11370, (718) 899-5200.

For additional information call 1-800-338-8113 or 1-718-899-3600 between 9:00 a.m. and 6:00 p.m. on weekdays.

SANUS/NEW YORK LIFE

OUT-PATIENT CARE

PHYSICIANS' OFFICE VISITS

SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-PATIENT

LABORATORY AND X-RAY SERVICES

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD

PHYSICIANS' AND SURGEONS' SERVICES

GENERAL NURSING CARE

DRUGS AND MEDICATION

DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)

INTENSIVE AND CORONARY CARE UNITS

USE OF OPERATING AND RECOVERY ROOM

ANESTHESIA

EMERGENCY CARE

AMBULANCE SERVICE

IN DOCTORS' OFFICES

HOSPITAL EMERGENCY ROOM

URGENT CARE FACILITY

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP

ROUTINE PEDIATRIC (WELL-BABY) CARE

IMMUNIZATIONS

ROUTINE HEARING EXAMINATIONS

VISION CARE

MENTAL HEALTH CARE

OUT-PATIENT DRUG ABUSE

ALCOHOL ABUSE

IN-PATIENT MENTAL HEALTH
DRUG ABUSE

ALCOHOL ABUSE

MENTAL HEALTH

MATERNITY CARE

IN PHYSICIANS' OFFICES

PRE-NATAL AND POST-NATAL VISITS

IN THE HOSPITAL

PHYSICIANS' SERVICES—MOTHER AND NEWBORN

NEWBORN NURSERY SERVICES

MOTHER'S HOSPITAL SERVICES

HOME HEALTH CARE

HOME CARE SERVICES

HOSPICE CARE

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL

SPEECH

DENTAL

PHARMACY SERVICES

FULL-TIME STUDENTS

Cost To You

*Covered in full—\$5 Co-payment for primary care physician only

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*\$10 Co-payment for primary care physician only

\$40 Co-payment. Waived if admitted to hospital

\$20 Co-payment

*\$5 Co-payment

*\$5 Co-payment

*\$5 Co-payment

*\$5 Co-payment

*\$5 Co-payment

†Covered in full—60-visit combined annual maximum for drug and/or alcohol treatment

†Covered in full—60-visit combined annual maximum for drug and/or alcohol treatment

*50% Co-payment for up to 20 visits annually

†Detoxification—Covered in full 3-14 days per episode; 30 days combined annual maximum for drug and/or alcohol treatment

Rehabilitation—Not Covered

†Detoxification—Covered in full 3-14 days per episode, 30 days combined annual maximum for drug and/or alcohol treatment

Rehabilitation—Not Covered

*Covered in full—30 days in-patient or 60 days in a day care program

*Covered in full

*Covered in full

*\$50 Co-payment per day

*Covered in full

*Covered in full

Not Covered

*Covered in full

*Covered in full—short term rehabilitation

*Covered in full—short term rehabilitation

**Covered according to Fee Schedule

See Optional Rider

Covered to age 23

*When provided or authorized by a SANUS/NEW YORK LIFE physician.

†When provided by a SANUS/NEW YORK LIFE physician or authorized by a SANUS/NEW YORK LIFE physician or referred by the Employee Assistance Program (EAP).

**Refer to SANUS/NEW YORK LIFE benefit booklet for details.

TOTAL HEALTH

TOTAL HEALTH is a comprehensive health care plan designed for New York and New Jersey residents.

TOTAL HEALTH has approximately 4,000 physicians who are located throughout the five boroughs of New York City, Nassau and Suffolk Counties, and New Jersey. TOTAL HEALTH doctors see TOTAL HEALTH members in the privacy and comfort of their private offices.

As a TOTAL HEALTH member, you select your own doctor from a list of participating doctors. Each adult family member selects an internist or family doctor. Parents select a pediatrician or family doctor for children under 12 years. You may choose one doctor for the entire family or, if you prefer, a different doctor for each family member. In addition to the primary care physician, each adult female member of the family will also select her own participating obstetrician/gynecologist.

Once you have selected your doctor, you will receive a TOTAL HEALTH gold membership card showing your doctor's name and telephone number. This doctor will manage all your health care needs. If you require the care of a specialist, including an obstetrician/gynecologist, your doctor will make the necessary referrals and arrangements for you. All visits to your doctor and to specialists recommended by your doctor are completely covered. If you are admitted to the hospital by your TOTAL HEALTH doctors, your hospital bill is paid by TOTAL HEALTH, including all approved surgery and anesthesia. There are no deductibles or co-payments. You will never have to fill out a claim form or wait for reimbursement.

Should you require additional specialty care, physical or rehabilitation therapy, vision or hearing examinations, home care, durable medical equipment, allergy testing and treatments, laboratory testing, X-rays, maternity and well-baby care, you are completely covered.

Your TOTAL HEALTH coverage protects you 24 hours a day, seven days a week for emergencies. An emergency is defined as sudden and unexpected acute illness, acute pain or accidental injury which if not immediately diagnosed and treated could reasonably be expected to result in serious medical complications or loss of life. Emergencies are covered 100% except a \$50 co-payment is charged if you are not admitted to the hospital. Examples of serious medical emergencies include heart attack, stroke, loss of consciousness, loss of respiration, convulsions, poisoning and severe pain. Emergency care is covered anywhere in the world.

TOTAL HEALTH members can receive discounts for certain weight reduction, smoking cessation, stress management and fitness programs.

Member Services representatives are available daily to answer your questions. They can be reached at (212) 617-1000, (718) 979-5555 or (516) 466-1000. For New Jersey residents, call (201) 361-8808 for further information, or (201) 361-3444 for member services if you are currently enrolled.

TOTAL HEALTH SENIOR PARTNER PLAN

This plan is not available to Medicare eligible retirees living in New Jersey.

Medicare eligible retirees residing in the New York Service area who join TOTAL HEALTH are enrolled in the Senior Partner Plan.

With TOTAL HEALTH Senior Partner Plan, you receive unlimited private doctor visits and check-ups in the privacy of the doctor's office, unlimited hospitalization in prestigious teaching and neighborhood hospitals, wellness and preventive care programs, eye and hearing exams and 24 hour emergency care 7 days a week, no matter where you are. There are no deductibles and no claim forms to file.

TOTAL HEALTH Senior Partner Plan members also receive prescription benefits (with limited exclusions) at a cost of \$1 for generic medications and \$5 for brand name medications. Prescriptions must be written by TOTAL HEALTH Senior Partner Plan participating physicians and filled at a participating pharmacy.

All medical care must be coordinated through your TOTAL HEALTH Senior Partner Plan physician and the TOTAL HEALTH delivery system. Medical care not coordinated through a TOTAL HEALTH Senior Partner Plan primary care physician or received outside the TOTAL HEALTH delivery system is not covered by TOTAL HEALTH Senior Partner Plan or Medicare, except in an emergency or urgent situation. See pages 42 and 43 for additional information on the TOTAL HEALTH Senior Partner Plan, an alternative Medicare program.

COST

An optional Prescription Drug Rider is available to all active employees and non-Medicare eligible retirees. For each prescription and refill you will pay only a \$3 co-payment at 400 participating pharmacies.

Please see page 45 for more information on payroll or pension deductions.

You may contact the health plan at 1010 Northern Boulevard, Suite 324, Great Neck, New York 11021, (212) 617-1000, (718) 979-5555, (516) 466-1000. For New Jersey residents, call (201) 361-8808 for further information, or (201) 361-3444 for member services if you are currently enrolled.

TOTAL HEALTH

OUT-PATIENT CARE

PHYSICIANS' OFFICE VISITS
 SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-
 PATIENT
 LABORATORY AND X-RAY SERVICES

Cost To You

*Covered in full
 *Covered in full
 *Covered in full

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
 PHYSICIANS' AND SURGEONS' SERVICES
 GENERAL NURSING CARE
 DRUGS AND MEDICATION
 DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
 INTENSIVE AND CORONARY CARE UNITS
 USE OF OPERATING AND RECOVERY ROOM
 ANESTHESIA

*Covered in full
 *Covered in full
 *Covered in full
 *Covered in full
 *Covered in full
 *Covered in full
 *Covered in full

EMERGENCY CARE

AMBULANCE SERVICE
 IN-DOCTORS' OFFICES
 HOSPITAL EMERGENCY ROOM
 URGENT CARE FACILITY

*Covered in full when medically necessary
 *Covered in full
 *\$50 co-payment unless followed by hospital admission
 *Covered in full

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
 ROUTINE PEDIATRIC (WELL-BABY) CARE
 IMMUNIZATIONS
 ROUTINE HEARING EXAMINATIONS
 VISION CARE

*Covered in full
 *Covered in full
 *Covered in full (except for travel)
 *Covered in full
 *Covered in full

MENTAL HEALTH CARE

OUT-PATIENT DRUG ABUSE
 ALCOHOL ABUSE
 MENTAL HEALTH
 IN-PATIENT DRUG ABUSE
 ALCOHOL ABUSE
 MENTAL HEALTH

†Covered in full—60 visit combined annual maximum for drug and/or alcohol treatment
 †Covered in full—60 visit combined annual maximum for drug and/or alcohol treatment
 *Covered for 20 visits/year with variable co-payments from \$0 to \$25
 †Detoxification: Covered in full 3-14 days treatment per admission; 30 day combined annual maximum for drug and/or alcohol treatment (23 days of which will be charged to the mental health benefit)
 Rehabilitation—Not Covered
 †Detoxification: Covered in full 3-14 days treatment per admission; 30 day combined annual maximum for drug and/or alcohol treatment (23 days of which will be charged to the mental health benefit)
 Rehabilitation—Not Covered
 *Covered in full 30 days in 365 day period (23 days of which may be applied to the drug and/or alcohol coverage)

MATERNITY CARE

IN PHYSICIANS' OFFICES
 PRE-NATAL AND POST-NATAL VISITS
 IN THE HOSPITAL
 PHYSICIANS' SERVICES—MOTHER AND NEWBORN
 NEWBORN NURSERY SERVICES
 MOTHER'S HOSPITAL SERVICES

*Covered in full
 *Covered in full
 *Covered in full
 *Covered in full
 *Covered in full

HOME HEALTH CARE

HOME CARE SERVICES
 HOSPICE CARE

*Covered in full when medically necessary
 *Covered in full when medically necessary
 *Covered in full when medically appropriate—100 day limit

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL
 SPEECH

*Covered in full—short-term rehabilitation
 *Covered in full—short-term rehabilitation
 See optional rider
 Covered to age 23

PHARMACY SERVICES

FULL-TIME STUDENTS

*When provided or authorized by TOTAL HEALTH primary care physician.

†When provided or authorized by TOTAL HEALTH primary care physician or referred by the Employee Assistance Program (EAP).

US HEALTHCARE

US Healthcare is a comprehensive health care plan which does more than simply pay the bills for your medical costs. US Healthcare has over 16 years experience in providing quality medical care to hundreds of thousands of people in the United States. Personal care is provided through family doctors located throughout New York (the five boroughs, Nassau, Suffolk, Orange, Putnam, Rockland and Westchester counties); the entire State of New Jersey; Pennsylvania (Southeastern Pennsylvania—Berks, Montgomery, Chester, Delaware, Philadelphia, Lehigh Valley and Bucks counties); Pittsburgh (Butler, Beaver, Allegheny, West Moreland, Washington, and Lafayette counties); Connecticut (Fairfield, New Haven, Litchfield and Hartford counties); Delaware (Kent and New Castle counties); and Massachusetts (Essex, Middlesex, Suffolk, Norfolk, and Plymouth counties).

When you become a member of US Healthcare, you and members of your family will be able to pick a family doctor, internist, or pediatrician from a list of 2,500 primary care doctors in the service area from the US Healthcare directory. As a special service to our female members, women age 17 or older are eligible to receive a yearly routine gynecological exam either by the primary care physician or by a participating US Healthcare gynecologist. Once you have selected a doctor, you will go to his or her office to receive the care you need. If you should need a specialist, the primary care doctor you have chosen will refer you and all visits are completely covered. Care will be coordinated between your primary care doctor and the specialist.

When you visit your primary care doctor, you will pay \$2 for that visit. All specialty care, hospitalization, surgery, intensive care, ambulance service, physical or rehabilitation therapy, home care, allergy treatments, vision or hearing examinations, anesthesia, diagnostic tests and X-rays are covered when medically necessary with a written referral from your primary care physician. US Healthcare will pay the whole bill—100%. There are no claim forms to fill out and no waiting for reimbursement.

Emergency care is covered anywhere in the world and all reasonable costs are reimbursed at 100% except for a co-payment of \$5 for a visit to the doctor's office or \$15 for a visit to an emergency room. If you are admitted to the hospital, the emergency room co-payment is waived.

Preventive dental care is also available for children under the age of twelve. It includes examination, cleaning, instruction in dental care, and fluoride treatments. Adults are covered for the removal of bony impacted wisdom teeth.

If you or someone in your family is faced with a rare or complicated illness, US Healthcare's National Medical Excellence Program will help you find the best medical care available at leading medical facilities located throughout the United States and provides 100% coverage.

For early detection of breast and colorectal cancer, our US HEALTHCHECK Program offers free mammographies and colorectal screening test kits to all eligible members.

As a member of US Healthcare, you will be able to take advantage of the Healthy Outlook Programs, which include the Healthy Breathing Program to help you stop smoking, Fitness Reimbursement which pays you to exercise, Stress Management, and the Healthy Eating Program to help lose and maintain your weight.

For more details on benefits and special programs, you may refer to information on the next page and on material included in US Healthcare's Benefits and Directory booklet which will be available during the transfer period or by calling the telephone numbers below. You will also need to pick a primary care physician and pharmacy, if it applies, for every family member on the City of New York enrollment forms (EB88 and P2r).

US HEALTHCARE MEDICARE

This plan is only available to retirees living in New York (Orange, Putnam, Westchester, Suffolk, Nassau, Rockland and the five boroughs) and Pennsylvania (Lehigh Valley, Berks, Bucks, Montgomery, Philadelphia, Delaware and Chester counties).

If you are Medicare eligible and retired with Parts A and B, you may join US Healthcare's Medicare Program. US Healthcare becomes your exclusive provider for Medicare benefits. It is not a supplemental plan and no other supplemental coverage is necessary. Retired Medicare eligibles will receive their health care as described above with expanded coverage to include durable medical equipment and hearing aids. There are no deductibles, no claim forms to file, and no coinsurance. All medical care must be coordinated through your US Healthcare primary care physician and the US Healthcare delivery system. Medical care received outside the US Healthcare system is not covered by US Healthcare or Medicare, except in an emergency or urgent situation. Please see pages 42 and 43 for more information on the US Healthcare Medicare Program. There is a separate listing of participating physicians and benefits for US Healthcare's Medicare Plan, which includes programs specifically designed for those 65 and over. Please call our Member Relations number below for the current Medicare primary physician list and more detailed information on US Healthcare's Medicare benefits.

COST

An optional prescription drug rider is available. Prescription drugs are available for a \$2.50 co-payment per prescription at a participating pharmacy.

Please see page 45 for more information on payroll or pension deductions.

You may contact the health plan with any questions at the member relations number, (212) 286-8670 or 1-800-445-USHC or by writing to US Healthcare, 980 Jolly Road, Blue Bell, PA 19422.

US HEALTHCARE

OUT-PATIENT CARE

PHYSICIANS' OFFICE VISITS

Cost To You

*Covered in full—\$2 co-payment for primary care physician only

SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-PATIENT

*Covered in full

LABORATORY AND X-RAY SERVICES

*Covered in full

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD

*Covered in full

PHYSICIANS' AND SURGEONS' SERVICES

*Covered in full

GENERAL NURSING CARE

*Covered in full

DRUGS AND MEDICATION

*Covered in full

DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)

*Covered in full

INTENSIVE AND CORONARY CARE UNITS

*Covered in full

USE OF OPERATING AND RECOVERY ROOM

*Covered in full

ANESTHESIA

*Covered in full

EMERGENCY CARE

AMBULANCE SERVICE

*Covered in full when medically necessary

IN DOCTORS' OFFICES

\$5 co-payment

HOSPITAL EMERGENCY ROOM

*\$15 co-payment. Waived if admitted into hospital

URGENT CARE FACILITY

*\$15 co-payment

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP

*\$2 co-payment

ROUTINE PEDIATRIC (WELL-BABY) CARE

*\$2 co-payment

IMMUNIZATIONS

*\$2 co-payment (except for travel)

ROUTINE HEARING EXAMINATIONS

*\$2 co-payment

VISION CARE

*\$2 co-payment

MENTAL HEALTH CARE

OUT-PATIENT DRUG ABUSE

†60 visit combined annual maximum for drug and/or alcohol treatment—\$2 co-payment per visit

ALCOHOL ABUSE

†60 visit combined annual maximum for drug and/or alcohol treatment—\$2 co-payment per visit

MENTAL HEALTH

*Covered for 20 visits; first 2 covered in full, next 18 with a variable co-payment of \$10 – \$25

IN-PATIENT DRUG ABUSE

†Detoxification: Covered in full for acute phase of treatment

ALCOHOL ABUSE

Rehabilitation—Not Covered

MENTAL HEALTH

†Detoxification: Covered in full for acute phase of treatment

Rehabilitation—Not Covered

*Covered 35 days in 365-day period

MATERNITY CARE

IN PHYSICIANS' OFFICES

*Covered in full

PRE-NATAL AND POST-NATAL VISITS

IN THE HOSPITAL

*Covered in full

PHYSICIANS' SERVICES—MOTHER AND NEWBORN

*Covered in full

NEWBORN NURSERY SERVICES

*Covered in full

MOTHER'S HOSPITAL SERVICES

HOME HEALTH CARE

HOME CARE SERVICES

*Covered in full when medically necessary

HOSPICE CARE

*Covered in full when medically necessary

SKILLED NURSING FACILITY

*Covered in full when medically appropriate

REHABILITATION

PHYSICAL

*Covered in full—short-term rehabilitation

SPEECH

*Covered in full—short-term rehabilitation

DENTAL

PHARMACY SERVICES

**Preventive care for children under age 12

FULL-TIME STUDENTS

See optional rider

Covered to age 23

*When provided or authorized by US Healthcare primary care physician.

†When provided or authorized by US Healthcare primary care physician or referred by Employee Assistance Program (EAP).

**Refer to US Healthcare's Benefits and Directory booklet.

DC 37 MED-TEAM

Available to DC 37 members (active or retired) only.

DC 37's Med-Team is an innovative health care program that offers a full range of coverage, all provided within local communities where members live or work and is coordinated as a "team". Med-Team* utilizes physicians and family practitioners in several boroughs of the City. Currently, active or retired DC 37 members in the Bronx, Manhattan, Brooklyn, Staten Island, Queens and Nassau are eligible for full coverage.

Participating physicians and practitioners have been selected on the basis of recommendations from medical directors and medical department chairpersons of community hospitals and health centers. These skilled providers, all of whom are either board-certified or board-eligible in their specialties, have agreed to work as a "team" in providing necessary care to eligible DC 37 members.

Members may choose their own primary care physicians (family practice, general medicine, pediatrics and ob/gyn) who will be responsible for managing care within a system of participating specialists, diagnostic facilities, and community-based hospitals. A \$5 co-payment is required when visiting primary care physicians. However, no charge is made when referred to participating specialists or other participants in the program.

DC 37 Med-Team enrollees must call TEAMCARE whenever hospitalization is needed or certain surgical procedures recommended. Failure to call may result in a co-payment of up to \$250 per hospital admission. Medicare eligible retirees and dependents with primary coverage other than Med-Team are not required to call TEAMCARE.

Med-Team Brooklyn provides physicians in private practice within the Sunset Park-Bay Ridge area with hospitalization when needed at Lutheran Medical Center.

Med-Team Bronx offers family-oriented care at Soundview Health Center with hospitalization at St. Barnabas Hospital.

- St. Barnabas Medical Group is a network of private physicians in private offices offering primary care around the St. Barnabas Hospital area.
- Montefiore Medical Group at Montefiore Medical Center also offers primary and specialist care as well as all diagnostic and ancillary services under one roof.

Med-Team Manhattan provides care within the St. Luke's/Roosevelt complex of facilities: Family Care Group Practice at West 114th Street with a family orientation uses either St. Luke's or Roosevelt Hospital for hospitalization.

- Sidney Hillman Health Center on East 16th St. offers family care along with specialists and diagnostic services under one roof. Hospitalization will be at Cabrini Medical Center and Beth Israel Medical Center.

Med-Team Staten Island provides physicians in private practice all over Staten Island with hospitalization at Staten Island Hospital.

Med-Team Queens-Nassau Community Health Plan (CHP) Medical Group is located at 3 sites in the Queens-Nassau area and is affiliated with Long Island Jewish Medical Center. It provides primary and specialist care as well as most services on site.

If you choose a non-participating provider, Med-Team will reimburse you according to a reduced fee schedule. This means there will be out-of-pocket costs for which the member is responsible. There is no deductible requirement.

MED-TEAM MEDICARE

Retirees with Medicare Parts A and B enjoy the benefit of having all coinsurance and deductibles covered by Med-Team. There is no optional benefits rider. In addition to supplementing payment for Medicare-covered services, Med-Team also provides coverage for routine physical examinations when using a Med-Team physician. See pages 42 and 43 for additional information on the Med-Team Medicare Program.

COST

There are no payroll or pension deductions for the basic Med-Team Program. There is no optional benefits rider.

You may contact the plan at 125 Barclay Street, 3rd floor, New York, N.Y. 10007, (212) 815-1313.

*At present, the program is underwritten by Empire Blue Cross and Blue Shield.

DC 37 MED-TEAM

OUT-PATIENT CARE

PHYSICIANS' OFFICE VISITS
SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-PATIENT
LABORATORY AND X-RAY SERVICES

Cost To You

*\$5 Co-payment

*Covered in full
*Covered in full

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
PHYSICIANS' AND SURGEONS' SERVICES
GENERAL NURSING CARE
DRUGS AND MEDICATION
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
INTENSIVE AND CORONARY CARE UNITS
USE OF OPERATING AND RECOVERY ROOM
ANESTHESIA

Covered in full
*Covered in full
Covered in full
Covered in full
*Covered in full
Covered in full
Covered in full
*Covered in full

EMERGENCY CARE

AMBULANCE SERVICE
IN DOCTORS' OFFICES
HOSPITAL EMERGENCY ROOM

Covered for \$100 or \$150 (depending on mileage)
*\$5 Co-payment
Covered by Empire Blue Cross and Blue Shield within 12 hrs. of an illness or 72 hrs. of an accident
Covered in full when authorized by a Med-Team physician

URGENT CARE FACILITY

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
ROUTINE PEDIATRIC (WELL-BABY) CARE
IMMUNIZATIONS
ROUTINE HEARING EXAMINATIONS
VISION CARE

**\$5 Co-payment
**\$5 Co-payment
**\$5 Co-payment

Not covered (covered through DC 37 Health & Security Plan)
Not covered (covered through DC 37 Health & Security Plan)

MENTAL HEALTH CARE

OUT-PATIENT	DRUG ABUSE
	ALCOHOL ABUSE
	MENTAL HEALTH
IN-PATIENT	DRUG ABUSE
	ALCOHOL ABUSE
	MENTAL HEALTH

+Covered in full—60 visit combined maximum for drug and/or alcohol treatment in a Med-Team approved facility.
+Covered in full—60 visit combined maximum for drug and/or alcohol treatment in a Med-Team approved facility.
Not Covered
+Detoxification—covered in full 7-14 days per episode in a Med-Team approved facility; 30-day combined annual maximum for drug, alcohol, and/or mental health treatment
Rehabilitation—Not Covered
+Detoxification—covered in full 5 days per episode in a Med-Team approved facility; 30-day combined annual maximum for drug, alcohol, and/or mental health treatment
Rehabilitation—Not Covered
Physician: covered in full. Hospitalization: 30 days per 12-month period in a psychiatric section of an approved general hospital or approved "specialty" hospital (government facilities not covered); 30-day combined annual maximum for drug, alcohol, and/or mental health treatment

MATERNITY CARE

IN PHYSICIANS' OFFICES
PRE-NATAL AND POST-NATAL VISITS
IN THE HOSPITAL
PHYSICIANS' SERVICES—MOTHER AND NEWBORN
NEWBORN NURSERY SERVICES
MOTHER'S HOSPITAL SERVICES

*Covered in full

Covered in full
Covered in full
Covered in full

HOME HEALTH CARE

HOME CARE SERVICES
HOSPICE CARE

*Covered in full 200 visits when authorized
*Covered in full 210 days when authorized
Not covered

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL

*Covered for 30 days in-hospital plus 30 out-patient visits between physical and speech

SPEECH

*Covered for 30 days in-hospital plus 30 out-patient visits between physical and speech

Through DC 37 Health and Security Plan
Covered to age 23 with proof of student status

PHARMACY SERVICES

FULL-TIME STUDENTS

*When using a Med-Team physician or authorized by a Med-Team physician (partial reimbursement for use of non-Med-Team services).

**Covered in full only when using a Med-Team physician.

+When provided or authorized by a Med-Team physician or referred by the Employee Assistance Program (EAP).

MED-PLAN

Med-Plan is offered to Health and Hospitals Corporation (HHC) employees and retirees and their dependents; current Med-Plan members who are not HHC employees may stay in the plan.

Med-Plan is a pre-paid group medical practice administered by Bellevue Hospital Center. Comprehensive health care is provided at the Med-Plan Center, 26th Street and First Avenue in Manhattan.

The emphasis at Med-Plan is on convenient, comprehensive, quality medical care. Med-Plan physicians (primary care as well as specialists) are board-certified or board-eligible in their medical fields and all are members of the teaching faculty of New York University School of Medicine.

Med-Plan members select a personal physician from among the Med-Plan primary care physicians. This physician provides primary care (check-ups, routine visits) and coordinates all health care needs through referrals to specialists as needed. In-patient care is provided at Bellevue Hospital Center.

As a member of Med-Plan you will be covered in full for a wide range of health care services including office visits, hospital visits and surgical care, emergency visits, maternity and pediatric care and psychiatric care. Some special features of Med-Plan include the preventive health, health education, and second surgical consultation services. There are no deductibles, no bills, no forms and no cost for covered services when authorized by Med-Plan.

The Med-Plan Center has convenient evening and weekend hours for scheduled appointments and urgent walk-ins. Monday through Thursday, 9:00 AM – 7:00 PM; Friday, 9:00 AM – 5:00 PM; Saturday, 9:00 AM – 2:30 PM (on an appointment basis). Every other Sunday, 9:00 AM – 2:30 PM (on an appointment basis).

Med-Plan has an Emergency Hotline which is open 24 hours/7 days a week. Members can call the Hotline any time they need help or advice for a medical problem. This service reduces the need for an emergency room visit.

OPTIONAL BENEFITS RIDER

Med-Plan offers an optional rider which provides prescription drugs at no charge when prescribed by a Med-Plan physician and dispensed through either Bellevue Hospital Center or one of the designated pharmacies in the Med-Plan vicinity. When ordered by Med-Plan, private-duty nursing in the hospital and covered appliances and prosthetics are covered. If your welfare fund provides benefits similar to those listed in the rider, those specific benefits will be provided through your welfare fund and your payroll deductions will be reduced accordingly.

MED-PLAN MEDICARE

Retirees who become Medicare eligible must withdraw from Med-Plan and choose another City health plan. Because Med-Plan physicians accept the Medicare assignments, you may continue to use Med-Plan doctors. You may continue seeing your Med-Plan physicians under Med-Plan's Special Medicare Program, but the procedures will be different since Med-Plan will no longer be your City health plan.

COST

All plan costs are noted on page 44.

You may contact the plan at 450 First Avenue, New York, N.Y. 10016, (212) 561-3335.

MED-PLAN

OUT-PATIENT CARE

PHYSICIANS' OFFICE VISITS
 SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-
 PATIENT
 LABORATORY AND X-RAY SERVICES

Cost To You

*Covered in full

*Covered in full

*Covered in full

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
 PHYSICIANS' AND SURGEONS' SERVICES
 GENERAL NURSING CARE
 DRUGS AND MEDICATION
 DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
 INTENSIVE AND CORONARY CARE UNITS
 USE OF OPERATING AND RECOVERY ROOM
 ANESTHESIA

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

EMERGENCY CARE

AMBULANCE SERVICE
 IN DOCTORS' OFFICES
 HOSPITAL EMERGENCY ROOM
 URGENT CARE FACILITY

Covered in full when authorized by Med-Plan

*Covered in full

*Covered in full

Covered in full only out-of-area

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
 ROUTINE PEDIATRIC (WELL-BABY) CARE
 IMMUNIZATIONS
 ROUTINE HEARING EXAMINATIONS
 VISION CARE

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

MENTAL HEALTH CARE

OUT-PATIENT	DRUG ABUSE
	ALCOHOL ABUSE
	MENTAL HEALTH
IN-PATIENT	DRUG ABUSE
	ALCOHOL ABUSE
	MENTAL HEALTH

**Covered in full—60 visit combined annual maximum for drug and/or alcohol treatment

**Covered in full—60 visit combined annual maximum for drug and/or alcohol treatment

Not Covered

**Detoxification—Covered in full up to 14 days per admission; 30-day combined annual maximum for drug, alcohol, and/or mental health treatment

Rehabilitation—Not Covered

**Detoxification—Covered in full up to 5 days per admission; 30-day combined annual maximum for drug, alcohol, and/or mental health treatment

Rehabilitation—Not Covered

*Covered in full—30 days per year in a psychiatric section of a general hospital; 30-day combined annual maximum for drug, alcohol, and/or mental health treatment

MATERNITY CARE

IN PHYSICIANS' OFFICES
 PRE-NATAL AND POST-NATAL VISITS
 IN THE HOSPITAL
 PHYSICIANS' SERVICES—MOTHER AND NEWBORN
 NEWBORN NURSERY SERVICES
 MOTHER'S HOSPITAL SERVICES

*Covered in full

*Covered in full

*Covered in full

*Covered in full

HOME HEALTH CARE

HOME CARE SERVICES
 HOSPICE CARE

*Covered in full

Not Covered

*Covered in full when medically appropriate

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL
 SPEECH

*Covered in full

Not Covered

Optional rider available

Covered to age 23

PHARMACY SERVICES

FULL-TIME STUDENTS

*When provided or authorized by a Med-Plan doctor.

**When provided or authorized by a Med-Plan doctor or referred by the Employee Assistance Program (EAP).

METROPOLITAN HEALTH PLAN

Metropolitan Health Plan is open to Health and Hospitals Corporation (HHC) employees, non-Medicare eligible retirees, and their dependents including full-time students up to age 23.

Metropolitan Health Plan (MHP) is a pre-paid health plan developed by N.Y.C. Health and Hospitals Corporation in partnership with Metropolitan Hospital Center and New York Medical College. The MHP physicians are based at Metropolitan Hospital Center, 1901 First Avenue, between 97th and 99th Streets. MHP is available to all eligible Health and Hospitals Corporation employees and non-Medicare eligible retirees and their dependents, including full-time students up to age 23. MHP offers its members comprehensive health care benefits and the convenience of receiving both medical and hospital services at one location. MHP members receive care in newly renovated in-patient and out-patient care areas.

As an MHP member you will select a primary care physician from a panel of MHP physicians. The physician you select provides and coordinates all your health care needs. A primary care provider facilitates continuity of care and access to specialty care. All MHP physicians are board certified or board eligible in their medical specialties and are on the faculty of New York Medical College.

As a member of MHP you will be covered for all hospital and surgical costs. Routine, urgent, and emergency visits, specialty care and even vision care are covered in full when using the MHP facility. There are no co-payments, no deductibles, no bills for covered services, and no waiting for reimbursement.

If a member needs medical or hospital care which cannot be provided at Metropolitan Hospital Center or if an emergency occurs outside the MHP service area, MHP covers these in full.

MHP has a team of membership service representatives available to assist members. They provide orientation to the plan, assist

members with questions and offer health education sessions. In addition, MHP has a 24 hour/7 days a week hotline telephone number in case you need help or advice for medical problems. The hotline is staffed by specially trained registered nurses with physicians on call if needed.

OPTIONAL BENEFITS RIDER

Metropolitan Health Plan offers an optional rider which provides prescription drugs at no charge when prescribed by an MHP physician. When ordered by Metropolitan Health Plan, private duty nursing in the hospital and covered appliances and prosthetics are also covered under the rider. If your welfare fund provides benefits similar to those listed in the rider, those specific benefits will be provided through your welfare fund and your payroll deductions will be reduced accordingly.

METROPOLITAN HEALTH PLAN MEDICARE

The Metropolitan Health Plan is not offered to Medicare eligible retirees.

COST

All plan costs are noted on page 44.

You may contact the health plan at Metropolitan Hospital Center, 1901 First Avenue, New York, N.Y. 10029, (212) 230-6334.

METROPOLITAN HEALTH PLAN

OUT-PATIENT CARE

PHYSICIANS' OFFICE VISITS

SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-PATIENT

LABORATORY AND X-RAY SERVICES

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD

PHYSICIANS' AND SURGEONS' SERVICES

GENERAL NURSING CARE

DRUGS AND MEDICATION

DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)

INTENSIVE AND CORONARY CARE UNITS

USE OF OPERATING AND RECOVERY ROOM

ANESTHESIA

EMERGENCY CARE

AMBULANCE SERVICE

IN DOCTORS' OFFICES

HOSPITAL EMERGENCY ROOM

URGENT CARE FACILITY

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP

ROUTINE PEDIATRIC (WELL-BABY) CARE

IMMUNIZATION

ROUTINE HEARING EXAMINATIONS

VISION CARE

MENTAL HEALTH CARE

OUT-PATIENT DRUG ABUSE

ALCOHOL ABUSE

IN-PATIENT MENTAL HEALTH
DRUG ABUSE

ALCOHOL ABUSE

MENTAL HEALTH

MATERNITY CARE

IN PHYSICIANS' OFFICES

PRE-NATAL AND POST-NATAL VISITS

IN THE HOSPITAL

PHYSICIANS' SERVICES—MOTHER AND NEWBORN

NEWBORN NURSERY SERVICES

MOTHER'S HOSPITAL SERVICES

HOME HEALTH CARE

HOME CARE SERVICES

HOSPICE CARE

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL

SPEECH

PHARMACY SERVICES

FULL-TIME STUDENTS

Cost To You

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

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*Covered in full

*Covered in full

**Covered in full—60 visit combined maximum for drug and/or alcohol treatment/calendar year

**Covered in full—60 visit combined maximum for drug and/or alcohol treatment/calendar year

*Covered for 20 visits/calendar year

**Detoxification—Covered in full up to 14 days per admission; 30 day combined annual maximum for alcohol, drug, and/or mental health treatment

Rehabilitation—Not Covered

**Detoxification—Covered in full up to 5 days per admission; 30 day combined annual maximum for alcohol, drug, and/or mental health treatment

Rehabilitation—Not Covered

*Covered in full 30 days, 30-day combined annual maximum for alcohol, drug, and/or mental health treatment

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full—Intermittent Nursing Service
Not Covered

*Covered in lieu of hospitalization when medically necessary

*Covered in full—short term

*Covered in full—short term

See optional rider

Covered to age 23

*When provided or authorized by a Metropolitan Health Plan physician.

**When provided or authorized by a Metropolitan Health Plan physician or referred by the Employee Assistance Program (EAP).

MID-HUDSON HEALTH PLAN

This plan is open only to employees and retirees residing in Columbia, Greene, Delaware and Ulster Counties and a portion of Northern Dutchess County including Red Hook and Rhinebeck. Medicare eligibles can join this plan.

The Mid-Hudson Health Plan (MHP) is a network model Health Maintenance Organization (HMO), offering its members the opportunity to receive health care services at a participating physician's private office. Each MHP member selects his or her own primary care physician, thereby maintaining the traditional doctor/patient relationship. Physician visits require a \$3 co-payment.

As an MHP member you and each member of your family will choose a primary care physician from MHP's list of participating providers. For adults, the primary care physician will specialize in either internal medicine or family practice and for children, specialization will be in either pediatrics or family practice. Your primary care physician is your key to the Mid-Hudson Health Plan. He or she will coordinate all health care services, including referrals which must be arranged for and authorized by your primary care physician. In this way, MHP is able to meet all your health care needs.

MHP members receive full coverage for in-patient hospital care when arranged for and authorized by their primary care physician. Most inpatient care will be provided at the following hospitals: Benedictine Hospital (Kingston); Columbia Memorial Hospital (Hudson); Ellenville Hospital (Ellenville); Kingston Hospital (Kingston); Margaretville Hospital (Margaretville); Memorial Hospital (Catskill); and Nursing Home of Greene County; Northern Dutchess Hospital (Rhinebeck); St. Francis Hospital (Poughkeepsie); and Vassar Hospital (Poughkeepsie). Specialized care not available in local hospitals may be referred to Mid-Hudson's tertiary medical center—New York Medical College/Westchester County Medical Center (Valhalla). In addition medically necessary services not provided by these hospitals or MHP-affiliated providers will be arranged by your primary care physician and covered in full.

Emergency care is covered, provided that the services are authorized by your MHP primary care physician. For life-threatening emergencies, members receive immediate care and then are expected to call their MHP physicians within 48 hours of receiving care. Members are covered 24 hours a day/7 days a week.

MHP care is comprehensive. Routine health care, office visits, allergy tests and treatment, eye and ear exams, laboratory services, X-rays, diagnostic tests, second surgical opinions, medical social

services, health education, well-baby care, well-child care, prenatal and post-natal care, services of a physician, surgeon, or anesthesiologist, emergency services, skilled nursing care, mental health care, and physical therapy and rehabilitation are all covered. In addition, unmarried, full-time student dependents are covered to age 25.

Beginning January 1, 1989, Mid-Hudson basic benefits are expanded to include vision care. In addition to a vision exam each year, each member is entitled to one pair of prescription eye glasses every two years for a \$25 co-payment or an allowance toward the cost of contact lenses.

MID-HUDSON HEALTH PLAN (MHP) MEDICARE COVERAGE

If you are Medicare eligible and retired with both Medicare Parts A and B you are also eligible for MHP. This plan provides the same comprehensive benefits of the standard MHP program which includes coverage for deductibles, coinsurance, and services not covered by Medicare Parts A and B, but not to exceed the standard coverage provided through MHP's program. To be covered in full, Medicare eligibles must use MHP physicians. If a non-MHP physician is used, only Medicare coverage is applicable and care is subject to deductibles, co-payments, and exclusions. See pages 42 and 43 for additional information on the MHP Medicare program.

Employees or retirees who have questions about this coverage may contact the MHP Member Services Department at the telephone number below.

COST

A prescription drug rider, requiring a \$3 co-payment per prescription at a participating pharmacy is available to all Mid-Hudson Health Plan subscribers.

Please see page 45 for more information on payroll deductions.

You may contact the health plan at: Hurley Avenue Extension, Parkwest Office Complex, Kingston, New York 12401, (914) 338-0202 or 1-800-826-2651.

MID-HUDSON HEALTH PLAN

OUT-PATIENT CARE

PHYSICIANS' OFFICE VISITS
 SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-
 PATIENT
 LABORATORY AND X-RAY SERVICES

Cost To You

*\$3 co-payment per visit

*\$3 co-payment per visit

*Covered in full

HOSPITAL CARE

SEMI-PRIVATE ROOM AND BOARD
 PHYSICIANS' AND SURGEONS' SERVICES
 GENERAL NURSING CARE
 DRUGS AND MEDICATION
 DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)
 INTENSIVE AND CORONARY CARE UNITS
 USE OF OPERATING AND RECOVERY ROOM
 ANESTHESIA

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

*Covered in full

EMERGENCY CARE

AMBULANCE SERVICE
 IN DOCTORS' OFFICES
 HOSPITAL EMERGENCY ROOM
 URGENT CARE FACILITY

*Covered in full

*Covered in full

*Covered in full

*Covered in full

PREVENTIVE CARE

ROUTINE PHYSICAL CHECK-UP
 ROUTINE PEDIATRIC (WELL-BABY) CARE
 IMMUNIZATIONS
 ROUTINE HEARING EXAMINATIONS
 VISION CARE

*\$3 co-payment per visit

*\$3 co-payment per visit

*\$3 co-payment per visit

*\$3 co-payment per visit

*\$3 co-payment per visit

MENTAL HEALTH CARE

OUT-PATIENT DRUG ABUSE
 ALCOHOL ABUSE
 MENTAL HEALTH

**60 visit combined annual maximum for drug and/or alcohol treatment—\$3 co-payment per visit

**60 visit combined annual maximum for drug and/or alcohol treatment—\$3 co-payment per visit

*Up to 20 visits per member per contract year—\$3 co-payment per visit

IN-PATIENT DRUG ABUSE

**Detoxification: Covered in full 3-14 days per episode; 30 day combined annual maximum for drug and/or alcohol treatment

*Rehabilitation: Covered in full, 30 day combined annual maximum for drug and/or alcohol treatment

**Detoxification: Covered in full 3-14 days per episode; 30 day combined annual maximum for drug and/or alcohol treatment

*Rehabilitation: Covered in full, 30 day combined annual maximum for drug and/or alcohol treatment

*Covered in full—30 day annual maximum

MENTAL HEALTH

MATERNITY CARE

IN PHYSICIANS' OFFICES
 PRE-NATAL AND POST-NATAL VISITS
 IN THE HOSPITAL
 PHYSICIANS' SERVICES—MOTHER AND NEWBORN
 NEWBORN NURSERY SERVICES
 MOTHER'S HOSPITAL SERVICES

*\$3 co-payment per visit

*Covered in full

*Covered in full

*Covered in full

HOME HEALTH CARE

HOME CARE SERVICES
 HOSPICE CARE

*Covered in full

*Covered in full up to 210 days when certified as appropriate

*Covered in full when medically appropriate

SKILLED NURSING FACILITY

REHABILITATION

PHYSICAL

*Covered in full—60 day maximum, in-patient and out-patient

*Evaluation only—covered in full

See optional rider

Covered to age 25

SPEECH

PHARMACY SERVICES

FULL-TIME STUDENTS

*When using Mid-Hudson physicians or referred by a Mid-Hudson physician.

**When using Mid-Hudson physicians or referred by a Mid-Hudson physician or referred by the Employee Assistance Program (EAP).

WELLCARE OF NEW YORK

This plan is open only to employees and retirees residing in Orange, Rockland, Putnam, Dutchess, and Sullivan Counties. Medicare eligibles can join this plan.

WellCare of New York (WCNY) is a Health Maintenance Organization (HMO), offering its members the opportunity to receive health care services at a participating physician's private office. Each WCNY member selects his or her primary care physician, thereby maintaining the traditional doctor/patient relationship. Physician visits require a \$3 co-payment.

As a WCNY member you and each member of your family will choose a primary care physician from WCNY's list of participating providers. For adults, the primary care physician will specialize in either internal medicine or family practice and for children, specialization will be either pediatrics or family practice. Your primary care physician is your key to WellCare of New York. He or she will coordinate all health care services, including referrals which must be arranged for and authorized by your primary care physician. In this way, WCNY is able to meet all your health care needs.

WCNY members receive full coverage for in-patient hospital care when arranged for and authorized by their primary care physician. Most in-patient care will be provided at the following hospitals: Arden Hill (Goshen); Benedictine Hospital (Kingston); Cornwall Hospital (Cornwall); Community General Hospital Sullivan County (Harris); Craig House (Beacon); Good Samaritan Hospital (Suffern); Helen Hayes Hospital (Haverstraw); Horton Memorial Hospital (Middletown); Julia B. Butterfield (Cold Springs); Mercy Community Hospital (Port Jervis); Nyack Hospital (Nyack); St. Anthony's Hospital (Warwick); St. Lukes Hospital (Newburgh); St. Francis Hospital (Poughkeepsie); St. Francis Hospital (Beacon); and Vassar Hospital (Poughkeepsie). Specialized care not available in local hospitals may be referred to WellCare's tertiary medical center—New York Medical College/Westchester County Medical Center (Valhalla). In addition, medically necessary services not provided by these hospitals or WCNY-affiliated providers will be arranged by your primary care physician and covered in full.

Emergency care is covered, provided that the services are authorized by your WCNY primary care physician. For life-threatening emergencies, members receive immediate care and then are expected to call their physician within 48 hours of receiving care. Members are covered 24 hours a day/7 days a week.

WCNY care is comprehensive. Routine health care, office visits, allergy tests and treatment, eye and ear exams, laboratory services, X-rays, diagnostic tests, second surgical opinions, medical social services, health education, well-baby care, well-child care, prenatal and post-natal care, skilled nursing care, mental health care, and physical therapy and rehabilitation are all covered. In addition, unmarried, full-time student dependents are covered to age 25.

Beginning January 1, 1989, WellCare of New York basic benefits are expanded to include vision care. In addition to a vision exam each year, each member is entitled to one pair of prescription eyeglasses every two years for a \$25 co-payment or an allowance toward the cost of contact lenses.

WELLCARE OF NEW YORK (WCNY) MEDICARE COVERAGE

If you are Medicare eligible and retired with both Medicare Parts A and B, you are also eligible for WCNY. This plan provides the same comprehensive benefits of the standard WCNY program which includes coverage for deductibles, coinsurance, and services not covered by Medicare Parts A and B, but not to exceed the standard coverage provided through WCNY program. To be covered in full, Medicare eligibles must use WCNY physicians. If a non-WCNY physician is used, only Medicare coverage is applicable and care is subject to deductibles, co-payments, and exclusions. See pages 42 and 43 for additional information on the WCNY Medicare program.

Employees or retirees who have questions about this coverage may contact the WellCare Member Services Department at the telephone number below.

COST

A prescription rider, requiring a \$3 co-payment per prescription at a participating pharmacy, is available to all WellCare of New York subscribers.

Please see page 45 for more information on payroll or pension deductions.

You may contact the health plan at: 300 Stony Brook Court, Newburgh, NY 12550, (914) 561-5028 or 1-800-826-2651.

WELLCARE OF NEW YORK

OUT-PATIENT CARE		Cost To You
PHYSICIANS' OFFICE VISITS		*\$3 co-payment per visit
SURGERY—PHYSICIANS' OFFICE OR HOSPITAL OUT-PATIENT		*\$3 co-payment per visit
LABORATORY AND X-RAY SERVICES		*Covered in full
HOSPITAL CARE		
SEMI-PRIVATE ROOM AND BOARD		*Covered in full
PHYSICIANS' AND SURGEONS' SERVICES		*Covered in full
GENERAL NURSING CARE		*Covered in full
DRUGS AND MEDICATION		*Covered in full
DIAGNOSTIC SERVICES (LAB WORK, X-RAYS)		*Covered in full
INTENSIVE AND CORONARY CARE UNITS		*Covered in full
USE OF OPERATING AND RECOVERY ROOM		*Covered in full
ANESTHESIA		*Covered in full
EMERGENCY CARE		
AMBULANCE SERVICE		*Covered in full
IN DOCTORS' OFFICES		*Covered in full
HOSPITAL EMERGENCY ROOM		*Covered in full
URGENT CARE FACILITY		*Covered in full
PREVENTIVE CARE		
ROUTINE PHYSICAL CHECK-UP		*\$3 co-payment per visit
ROUTINE PEDIATRIC (WELL-BABY) CARE		*\$3 co-payment per visit
IMMUNIZATIONS		*\$3 co-payment per visit
ROUTINE HEARING EXAMINATIONS		*\$3 co-payment per visit
VISION CARE		*\$3 co-payment per visit
MENTAL HEALTH CARE		
OUT-PATIENT	DRUG ABUSE	**60 visit combined annual maximum for drug and/or alcohol treatment—\$3 co-payment per visit
	ALCOHOL ABUSE	**60 visit combined annual maximum for drug and/or alcohol treatment—\$3 co-payment per visit
	MENTAL HEALTH	*Up to 20 visits per member per contract year—\$3 co-payment per visit
IN-PATIENT	DRUG ABUSE	*Detoxification—Covered in full up to 7 days; 30 days combined annual maximum for drug and/or alcohol treatment
	ALCOHOL ABUSE	*Rehabilitation: Covered in full; 30 day combined annual maximum for drug and/or alcohol treatment
	MENTAL HEALTH	*Detoxification—Covered in full up to 7 days; 30 days combined annual maximum for drug and/or alcohol treatment
		*Rehabilitation: Covered in full; 30 day combined annual maximum for drug and/or alcohol treatment
		*Covered in full—30 day maximum per year
MATERNITY CARE		
IN PHYSICIANS' OFFICES		*\$3 co-payment per visit
PRE-NATAL AND POST-NATAL VISITS		
IN THE HOSPITAL		
PHYSICIANS' SERVICES—MOTHER & NEWBORN		*Covered in full
NEWBORN NURSERY SERVICES		*Covered in full
MOTHER'S HOSPITAL SERVICES		*Covered in full
HOME HEALTH CARE		
HOME CARE SERVICES		*Covered in full
HOSPICE CARE		*Covered in full up to 210 days when certified as appropriate
SKILLED NURSING FACILITY		*Covered in full when medically appropriate
REHABILITATION		
PHYSICAL		*Covered in full—60 day maximum, in-patient and out-patient
SPEECH		*Evaluation only—covered in full
PHARMACY SERVICES		*See optional rider
FULL-TIME STUDENTS		Covered to age 25

* When using WellCare physicians or referred by a WellCare physician.

** When using WellCare physicians or referred by a WellCare physician or referred by the Employee Assistance Program (EAP).

COMPARISON OF BENEFITS FOR RETIREES AND THEIR DEPENDENTS COVERED BY MEDICARE FOR NON-HMO AND HMO PLANS

Non HMO's	Medicare Part B Deductible	Office Visit	X-Ray/Lab Test—Out-Patient	Specialist Consultations—Out-of-Hospital	Radiation Therapy (Out-Patient)
GHI/Empire Blue Cross and Blue Shield Senior Care (GHI-CBP and GHI Type C Enrollees)	Reimburses the \$75 if met by any covered services: in-hospital medical care or out-of-hospital medical care.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.
Med-Team	Reimburses the \$75 if met by any covered services: in-hospital medical care or out-of-hospital medical care.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.

ADDITIONAL BENEFITS COVERED UNDER GHI SENIOR CARE INCLUDE: *SURGERY, IN-HOSPITAL SPECIALIST CONSULTATIONS, IN-HOSPITAL MEDICAL CARE, AND ANESTHESIA*, WHICH ARE REIMBURSED AT 20% OF THE AMOUNT APPROVED BY MEDICARE. UNLIMITED HOSPITALIZATION IS PROVIDED BY MEDICARE IN COMBINATION WITH EMPIRE BLUE CROSS AND BLUE SHIELD.

HMO's	Medicare Part B Deductible	Office Visit	X-Ray/Lab Test—Out-Patient	Specialist Consultations—Out-of-Hospital	Radiation Therapy
HIP/Medicare Supplemental Program* (Current Members Only)	No deductible.	Covered in full.	Covered in full.	Covered in full.	Covered in full.
HIP VIP**	No deductible.	Covered in full.	Covered in full.	Covered in full.	Covered in full.
Empire Blue Cross and Blue Shield HEALTHNET*	No deductible.	Covered in full with a \$5 co-payment.	Covered in full.	Covered in full.	Covered in full.
US Healthcare** NY and PA only. Not available to NJ or Conn. residents	No deductible.	Covered in full with \$2 co-payment.	Covered in full.	Covered in full.	Covered in full.
Mid-Hudson*	No deductible.	Covered in full with \$3 co-payment.	Covered in full.	Covered in full.	Covered in full.
WellCare*	No deductible.	Covered in full with \$3 co-payment.	Covered in full.	Covered in full.	Covered in full.
Sanus/New York Life*	No deductible.	Covered in full with \$5 co-payment.	Covered in full.	Covered in full.	Covered in full.
TOTAL HEALTH**	No deductible.	Covered in full.	Covered in full.	Covered in full.	Covered in full.

ALL HMO PLANS INCLUDE ADDITIONAL BENEFITS PROVIDED IN FULL: SURGERY (IN AND OUT OF HOSPITAL), ANESTHESIA, IN-HOSPITAL CONSULTATIONS, IN-HOSPITAL MEDICAL CARE, HOSPITALIZATION

*COVERAGE LEVELS INDICATED APPLY ONLY IF CARE IS PROVIDED OR AUTHORIZED BY A PARTICIPATING PHYSICIAN. IF A NON-PARTICIPATING PHYSICIAN IS USED, ONLY MEDICARE BENEFITS APPLY; MEDICARE DEDUCTIBLES, COINSURANCE PAYMENTS, AND EXCLUSIONS ARE IN EFFECT.

**MEDICARE RISK HEALTH PLANS: SEE DEFINITIONS SECTION IN FRONT OF BOOKLET FOR FURTHER EXPLANATION.

COMPARISON OF BENEFITS FOR RETIREES AND THEIR DEPENDENTS COVERED BY MEDICARE FOR NON-HMO AND HMO PLANS

Appliances	Ambulance Service	Private-Duty Nursing	Prescription Drugs	Out-of-Hospital Psychiatric Care	In-Patient Psychiatric Care
Reimburses 20% of the amount approved by Medicare subject to \$25 family deductible per year. (\$2,500 annual max per person, includes private-duty nursing and ambulance benefits).	Same as appliance coverage.	Reimburses 80% subject to same deductible and \$2,500 annual maximum per person as appliance and ambulance coverage.	Coverage available under optional rider. 80% reimbursed after \$150 deductible is met; up to \$2,500 per year. Maintenance drugs: \$8 co-pay per prescription. No deductible. No coinsurance.	Not covered.	Reimburses 20% of the amount approved by Medicare.
Reimburses 20% of the amount approved by Medicare.	Reimburses 20% of the amount approved by Medicare.	Reimburses 80% after the first 72 hours when authorized by a physician; subject to a \$100 yearly deductible.	Available through DC-37 Health and Security Plan.	Not covered.	Reimburses 20% of the amount approved by Medicare.

ADDITIONAL BENEFITS COVERED UNDER GHI SENIOR CARE INCLUDE: *SURGERY, IN-HOSPITAL SPECIALIST CONSULTATIONS, IN-HOSPITAL MEDICAL CARE, AND ANESTHESIA*, WHICH ARE REIMBURSED AT 20% OF THE AMOUNT APPROVED BY MEDICARE. UNLIMITED HOSPITALIZATION IS PROVIDED BY MEDICARE IN COMBINATION WITH EMPIRE BLUE CROSS AND BLUE SHIELD.

Appliances	Ambulance Service	Private-Duty Nursing	Prescription Drugs	Out-of-Hospital Psychiatric Care	In-Patient Psychiatric Care
Covered in full when prescribed by an HIP physician and obtained through HIP designated appliance vendors.	Covered in full.	In-hospital only. Covered in full when prescribed by an HIP physician or in a covered emergency.	Full coverage available under optional drug rider.	One psychiatric assessment visit covered in full at HIP/ HMO Mental Health Center and short term therapy through HIP Mental Health Service.	HIP will pay the deductible and co-payment not paid by Medicare up to Maximum 190 lifetime days.
Covered in full when prescribed by an HIP physician and obtained through HIP designated appliance vendors.	Covered in full.	In-hospital only. Covered in full when prescribed by an HIP physician or in a covered emergency.	Covered in full when prescribed by HIP doctors and obtained from an HIP Participating Pharmacy.	One psychiatric assessment and 20 out-patient visits per year covered in full at an HIP Mental Health Center.	Covered in full up to maximum of 190 lifetime days.
Covered in full.	Covered in full.	Covered in full.	Coverage available under rider.	Covered in full up to 20 visits per year with \$25 co-payment when authorized by a HEALTHNET physician.	Covered up to 30 days when admitted by a HEALTHNET physician.
Covered in full when medically necessary and coordinated by US Healthcare Home Care and your primary care physician.	Covered in full.	Covered in full.	Covered under rider (\$2.50 co-payment). Available for N.Y. residents only.	Covered for 20 visits, first 2 covered in full—next 18 with a variable co-payment of \$10-\$25.	Covered in full for 190 days lifetime maximum when referred by primary care physician.
Covered in full.	Covered in full.	Covered in full.	Out-patient \$3 co-payment per prescription.	Covered in full up to 20 visits per year with a \$3 co-payment when authorized by a (MHP) physician.	Covered up to 30 days when admitted by a (MHP) physician.
Covered in full.	Covered in full.	Covered in full.	Out-patient \$3 co-payment per prescription.	Covered in full up to 20 visits per year with a \$3 co-payment when authorized by a (WCNY) physician.	Covered up to 30 days when admitted by a (WCNY) physician.
Covered in full.	If not an emergency, covered when authorized by a Sanus/ New York Life primary care physician and approved by a Sanus/New York Life Medical Director.	Covered in full.	Coverage available under rider. (\$50 deductible for non-mail service drugs per individual, per year with \$3 co-payment per prescription. *Maintenance drugs filled at no charge.	Covered up to 20 visits per year with a 50% co-payment when authorized by a Sanus/ New York Life Medical Director.	Covered up to 30 days when admitted by a Sanus/New York Life physician.
Covered in full when medically necessary, coordinated by your TOTAL HEALTH primary care physician and obtained through designated appliance vendors.	If not an emergency, covered when authorized by a TOTAL HEALTH primary care physician and approved by the TOTAL HEALTH Medical Director.	Covered in hospital only. Covered in full when prescribed by a TOTAL HEALTH doctor and medically necessary.	Out-patient drugs \$1 for generic medications and \$5 for brand medications at participating pharmacies. In-patient drugs covered in full.	Covered for 20 visits; first 2 covered in full, next 18 with a variable co-payment of \$10-\$25.	Covered in full for 190 days lifetime maximum when using TOTAL HEALTH system.

NOTE: ALL MEDICAL CARE MUST BE AUTHORIZED BY THE HMO PLAN PHYSICIAN IN ORDER TO BE COVERED IN FULL, EXCEPT IN EMERGENCY CARE SITUATIONS.

BASIC PLAN AND OPTIONAL RIDER COSTS

Basic coverage is available at no cost to the subscriber under certain plans, while other plans require a payroll or pension deduction. A rider for optional benefits may be purchased under all but one of the plans (Med-Team does not offer an optional rider).

Basic plan and rider costs are given below, along with a description of the rider package available for each plan.

Each rider is a package. You may not select individual benefits in the rider. However, if your union welfare fund provides benefits similar to some or all of those listed in the rider for your plan, those specific benefits will be provided only by your welfare fund and will not be available through the health plan rider. In these cases payroll and pension deductions will be adjusted accordingly. (NOTE: If your health plan's optional rider only consists of a prescription drug plan and your welfare fund provides this same benefit, do not choose the rider as deductions will not be adjusted.)

	COSTS								
	Monthly		Bi-Weekly		Semi-Monthly		Weekly		Monthly
	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Medicare Eligible Retirees (per person)
GHI-CBP/EMPIRE BLUE CROSS BLUE SHIELD BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OPTIONAL RIDER** Prescription & Maintenance Drugs	\$ 8.45	\$15.48	\$ 3.89	\$ 7.13	\$ 4.23	\$ 7.74	\$ 1.94	\$ 3.56	\$20.73
365-Day EBCBS Hospitalization	\$ 7.95	\$18.53	\$ 3.66	\$ 8.53	\$ 3.98	\$ 9.27	\$ 1.83	\$ 4.26	Covered by Medicare
\$250 Maximum Co-insurance; (\$500 as of 1/1/90)	\$ 2.69	\$ 5.78	\$ 1.24	\$ 2.66	\$ 1.35	\$ 2.89	\$ 0.62	\$ 1.33	Not Available
In-patient Substance Abuse Treatment	\$ 2.54	\$ 5.38	\$ 1.17	\$ 2.48	\$ 1.27	\$ 2.69	\$ 0.58	\$ 1.24	Not Available
Out-Patient Psychiatric Care	\$ 3.50	\$ 5.40	\$ 1.61	\$ 2.49	\$ 1.75	\$ 2.70	\$ 0.81	\$ 1.24	Not Available
Empire Blue Cross and Blue Shield Coverage for students to age 23	—	\$ 3.19	—	\$ 1.47	—	\$ 1.60	—	\$ 0.73	Not Available
Newborn Well-baby care (Part of Basic Plan as of 7/1/89)	Covered in basic plan.		Covered in basic plan.		Covered in basic plan.		Covered in basic plan.		Not Available
Average 50% increase in Major Medical Reimbursement Schedule (As of 1/1/90)	\$ 5.68	\$15.36	\$ 2.61	\$ 7.07	\$ 2.84	\$ 7.68	\$ 1.31	\$ 3.53	Not Available
GHI TYPE C/EMPIRE BLUE CROSS BLUE SHIELD BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OPTIONAL RIDER** Prescription & Maintenance Drugs	\$ 8.45	\$15.48	\$ 3.89	\$ 7.13	\$ 4.23	\$ 7.74	\$ 1.94	\$ 3.56	\$20.73
365-Day EBCBS Hospitalization	\$ 7.95	\$18.53	\$ 3.66	\$ 8.53	\$ 3.98	\$ 9.27	\$ 1.83	\$ 4.26	Covered by Medicare
MED-PLAN BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	Not Available
OPTIONAL RIDER** Prescription Drugs	\$13.08	\$35.30	\$ 6.02	\$16.25	\$ 6.54	\$17.65	\$ 3.01	\$ 8.12	Not Available
Appliances and Private Duty Nursing	\$ 0.79	\$ 2.13	\$ 0.36	\$ 0.98	\$ 0.40	\$ 1.07	\$ 0.18	\$ 0.49	Not Available
METROPOLITAN HEALTH PLAN BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	Not Available
OPTIONAL RIDER** Prescription Drugs	\$13.08	\$35.30	\$ 6.02	\$16.25	\$ 6.54	\$17.65	\$ 3.01	\$ 8.12	Not Available
Appliances and Private Duty Nursing	\$ 0.79	\$ 2.13	\$ 0.36	\$ 0.98	\$ 0.40	\$ 1.07	\$ 0.18	\$ 0.49	Not Available
									MSP
									VIP
HIP/HMO BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OPTIONAL RIDER** Prescription Drugs	\$13.08	\$35.30	\$ 6.02	\$16.25	\$ 6.54	\$17.65	\$ 3.01	\$ 8.12	\$24.54
Appliances and Private Duty Nursing	\$ 0.79	\$ 2.13	\$ 0.36	\$ 0.98	\$ 0.40	\$ 1.07	\$ 0.18	\$ 0.49	Covered in basic
									Covered in basic

** OPTIONAL RIDER—Rates are effective July 1, 1989.

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	COSTS									
	Monthly		Bi-Weekly		Semi-Monthly		Weekly		Monthly	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Medicare Eligible Retirees (per person)	
SANUS/NEW YORK LIFE BASIC PLAN*	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	
OPTIONAL RIDER** Prescription and Maintenance Drugs	\$ 3.70	\$10.10	\$ 1.70	\$ 4.65	\$ 1.85	\$ 5.05	\$ 0.85	\$ 2.32	\$27.90	
TOTAL HEALTH BASIC PLAN*	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	
OPTIONAL RIDER** Prescription Drugs	\$ 7.20	\$19.73	\$ 3.31	\$ 9.08	\$ 3.60	\$ 9.87	\$ 1.66	\$ 4.54	Covered in basic	
US HEALTHCARE BASIC PLAN*	\$15.13	\$34.40	\$ 6.96	\$15.83	\$ 7.57	\$17.20	\$ 3.48	\$ 7.92	-0-	
OPTIONAL RIDER** Prescription Drugs	\$ 8.10	\$20.90	\$ 3.73	\$ 9.62	\$ 4.05	\$10.45	\$ 1.86	\$ 4.81	\$49.80	
MID-HUDSON HEALTH PLAN BASIC PLAN*	\$ 5.83	\$ 7.20	\$ 2.68	\$ 3.31	\$ 2.92	\$ 3.60	\$ 1.34	\$ 1.66	-0-	
OPTIONAL RIDER** Prescription Drugs	\$ 8.28	\$21.53	\$ 3.81	\$ 9.91	\$ 4.14	\$10.77	\$ 1.91	\$ 4.95	Covered in basic	
WELLCARE OF NEW YORK BASIC PLAN*	\$10.96	\$20.56	\$ 5.04	\$ 9.16	\$ 5.48	\$10.28	\$ 2.52	\$ 4.73	-0-	
OPTIONAL RIDER** Prescription Drugs	\$ 8.26	\$21.48	\$ 3.80	\$ 9.89	\$ 4.13	\$10.74	\$ 1.90	\$ 4.94	Covered in basic	
EBCBS HEALTHNET BASIC PLAN*	\$25.23	\$50.65	\$11.61	\$23.31	\$12.62	\$25.33	\$ 5.81	\$11.66	\$15.96	
OPTIONAL RIDER** Prescription Drugs	\$ 8.10	\$17.45	\$ 3.73	\$ 8.03	\$ 4.05	\$ 8.73	\$ 1.86	\$ 4.02	\$24.29	
MED-TEAM BASIC PLAN (No Rider Available)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	
HIP/CHOICE BASIC PLAN*	\$12.73	\$34.30	\$ 5.86	\$15.79	\$ 6.37	\$17.15	\$ 2.93	\$ 7.89	MSP	VIP
OPTIONAL RIDER** Prescription Drugs	\$12.29	\$33.17	\$ 5.66	\$15.27	\$ 6.15	\$16.59	\$ 2.83	\$ 7.63	\$24.54	Covered in basic

* BASIC PLAN—These are estimated rates and will be effective for July and August, 1989. In September, rates will be adjusted if needed. You will receive notification prior to implementation of any changes.

** OPTIONAL RIDER—Rates are effective July 1, 1989.

EXAMPLE OF CALCULATION OF PAYROLL DEDUCTION

Ms. Wolfe selects HIP/HMO with the HIP/HMO optional rider (family coverage) and her welfare fund provides a prescription drug plan. Her optional rider will consist of all the optional rider benefits minus the drug coverage. (She will obtain drug benefits through her fund). Her payroll deduction for the rider will be decreased by the cost of drug coverage.

HIP/HMO Optional Rider Cost	
Bi-weekly	Family
Prescription Drugs	\$16.25
+ Appliances and Private-Duty Nursing	+ \$ 0.98
Total Rider Cost	\$17.23
— Prescription drugs, provided by union welfare fund	— \$16.25
Cost to Ms. Wolfe	\$ 0.98

RETIREE TRANSFER PERIOD APPLICATION

(Use this form only if you are a retired City employee)



CITY OF NEW YORK
EMPLOYEE
BENEFITS PROGRAM

110 Church St., New York, N.Y. 10007

1989
TRANSFER
PERIOD

REASON(S) FOR SUBMISSION (Check one or more boxes; enter change date if appropriate)

☒ **1989 TRANSFER PERIOD** - All changes requested during the transfer period will be effective September 1, 1989. Incomplete applications will be returned for missing information and may delay the effective date of transfer. Please attach a photocopy of the Medicare card for all persons covered by Medicare.

- ☐ Address Change
☐ Change of Name
☐ Add Optional Benefits
☐ Drop Optional Benefits
☐ Cancel Benefits
☐ Waiver of Membership

Fill out only
Retiree Section
and sign form.

CHANGE OF:

- ☐ Marital Status
☐ Spouse Information
☐ Dependent Children
☐ Other _____

Date of Event
M D Y
/ /
/ /
/ /
/ /

RETIREE INFORMATION (Complete this section)

Last Name		First Name		M.I.	Social Security Number		Telephone No. ()	
Home Address - Number and Street				Apt. No.	City		State	Zip Code
Date of Birth / /		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<input type="checkbox"/> Legally Separated		Date of Event / /	
City Agency From Which Retired				Retirement Date / /		Name of Union or Welfare Fund		
Retirement System		Yrs. in Ret. Sys.	Are you receiving a pension check? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, Pension No.		Name of Current Health Plan <input type="checkbox"/> None	

SPOUSE INFORMATION (Complete only if currently married) (Do not complete if you are legally separated, divorced or widowed)

Spouse Social Security Number		Last Name (if different)		First Name		M.I.	
Date of Birth / /		Employed by or retired from New York City agency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is spouse to be covered by member? <input type="checkbox"/> Yes <input type="checkbox"/> No		(Spouse may not be covered as both a member and a dependent)		Employment Status <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired
Name & Address of Spouse's Current or Former Employer (including NYC)				Does spouse have own health coverage, other than Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Health Plan(s) and Policy Number(s)	

DEPENDENT CHILDREN INFORMATION (List each eligible child to be covered by, or dropped from retiree's plan)

First Name	Last Name (If Different)	Birth Date	Sex M/F	Check if applicable			This part for disabled child covered by Medicare			
				Full-Time Student	Permanently Disabled	DROP COVERAGE	Medicare Number		Effective Dates	
							Claim Number	Suffix	Hosp. Ins. (Part A)	Med. Ins. (Part B)
		/ /							/ /	/ /
		/ /							/ /	/ /
		/ /							/ /	/ /

MEDICARE INFORMATION (Complete if retiree and/or spouse is eligible for Medicare. Attach Medicare card photocopies)

RETIREE	Medicare Claim Number	Suffix	EFFECTIVE DATES		SPOUSE	Medicare Claim Number	Suffix	EFFECTIVE DATES	
			HOSP. INS. (PART A)	MED. INS. (PART B)				HOSP. INS. (PART A)	MED. INS. (PART B)
			/ /	/ /				/ /	/ /

HEALTH PLAN REQUESTED Check the box before the plan you want and check "Yes" or "No" for the optional benefits rider. If your plan requires you to choose a specific Medical Group (HIP plans), Primary Care Physician (other HMO's) or Hospital/Physician Network, you must indicate the name and number of the group or physician chosen.

- ☐ GHI-CBP/EBCBS
☐ GHI-TYPE C/EBCBS
☐ BLUE CROSS HEALTHNET
- ☐ HIP/HMO†
☐ HIP CHOICE†
☐ SANUS/NY LIFE

- ☐ TOTAL HEALTH†
☐ US HEALTHCARE*†

- ☐ MED-PLAN (HHC ONLY)
☐ METROPOLITAN (HHC Only)
☐ MED-TEAM (DC 37 Only)

- Upstate Counties Only
☐ MID-HUDSON
☐ WELLCARE

Optional Benefits? ☐ Yes ☐ No

*PHARMACY-US HEALTHCARE ONLY
(Fill in only if Optional Benefits chosen)

† Persons covered by Medicare must complete an additional special application available from the health plan.

Name & Number of Medical Group, Primary Physician or Hospital/Physician Network

AUTHORIZATION (Retiree—Please Sign And Date Below)

I certify that the above information is correct and I authorize the City to deduct from my retirement allowance the amount required, if any, through the City Employee Benefits Program. I understand that the City Program's benefits will be coordinated with those available through Medicare or any other source. If I have checked the Cancel Benefits or Waiver of Membership boxes above, I am choosing not to participate in the City Employee Benefits Program at this time.

RETIREE—DO NOT WRITE IN THIS SECTION

CERTIFICATION BY PAYROLL OR PERSONNEL OFFICE

I certify that the above retiree is eligible for the New York City Employee Benefits Program.

Retiree Signature

Date

Certifying Signature

Date



OFFICE OF MUNICIPAL LABOR RELATIONS

EMPLOYEE BENEFITS PROGRAM

110 CHURCH STREET, 12TH FLOOR, NEW YORK, N.Y. 10007

ROBERT W. LINN
Director, OMLR

JAMES F. HANLEY
1st Deputy Director, OMLR

DONNA LYNNE
Program Director

LEONARD LETO
Deputy Program Director

To: Operations Staff
From: Gail Laufer, ^{gl} Ass't. Director, Operations
Subject: Error in New Summary Program Description Booklet
Date: April 18, 1989

Please make a note of an error which inadvertently appears in the new Summary Program Description.

On page 45 the monthly rate for the Sanus/New York Life Basic Plan for Medicare Eligible Retirees is \$31.13 per person, not "-0-" as printed in the booklet.

Please make this correction on all SPD's which you mail out to retirees or make sure that a correction sheet is inserted with each booklet.

CORRECTION

On page 45 of this booklet the monthly cost for Medicare Eligible Retirees (per person) for Sanus/New York Life is \$31.13 not "-0-" as printed in the Summary Program Description Booklet.

City of New York/Employee Benefits Program

CORRECTION

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City of New York/Employee Benefits Program

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City of New York/Employee Benefits Program